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Medical Review in Skilled Nursing Homes and Mental Hospitals



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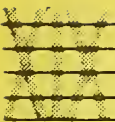
MEDICAL REVIEW IN SKILLED NURSING HOMES AND MENTAL HOSPITALS

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Part 5. Services and Payment in Medical Assistance Programs

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5-60-10 Legal Background and Authority

- A. Section 1902(a)(26) of the Social Security Act.
- B. 45 CFR 250.23
- C. SRS PR 40-21, February 17, 1971.

5-60-20 Implementation

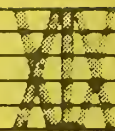
Introduction

This guideline document interprets and discusses the provisions of 45 CFR 250.23: "Periodic Medical Review and Medical Inspections in Skilled Nursing Homes and Mental Hospitals" which became effective May 3, 1971. It describes approaches that might be taken by single State agencies toward implementation of this regulation. It examines features of some medical review methods that have proven effective in a few jurisdictions; presents ideas and suggestions for the structuring and conduct of medical review programs; discusses the intent and implications of various components of the medical review process; and presents a number of aids that may be found of practical value in initiating or improving medical review activities called for under the regulation.

The medical review program called for by the regulation has two distinct parts which involve separate administrative processes. The first is a requirement for a medical evaluation of a patient's need for skilled nursing home care or for care in a mental hospital prior to admission. In the event that the individual already is an inpatient in the facility at the time application is made for title XIX benefits, the medical evaluation of need for care is called for prior to authorization of benefits. This medical evaluation ordinarily would be performed by the patient's attending physician.

The second part of the medical review program consists of a program of periodic inspections of the care of medical assistance patients who are inpatients in skilled nursing homes and mental hospitals.

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Stated simply, the purpose and function of periodic medical review is to ascertain and document whether medical assistance patients in title XIX skilled nursing homes and mental hospitals are, in fact, receiving physician, skilled nursing, personal, and social services for which they are eligible that are optimum in quality, adequate in quantity, and sufficient in scope; and are being provided in a timely manner under circumstances most favorable to the promotion of the physical, emotional, social, and functional well-being of such patients.

The primary goal of periodic medical review is to ensure the provision of a range and quality of medical and nursing management, and social work support, for title XIX skilled nursing home and mental hospital patients that is necessary and commensurate with their clinical and physical needs, and optimum social functioning. In that context, the three entities most affecting the well-being of an individual medical assistance patient are his physician, the provider institution and the case worker who serves him. Appraisal of how well each of these is responding, separately and in relation to each other, in providing quality care that is timely and conforms to accepted professional standards and practices is the key aim of the patient-centered evaluations required by section 250.23. A secondary role of periodic medical review entails matching the kinds of services actually needed by medical assistance patients with facilities most capable and best suited to render such care. The approach to such determinations should be as an aspect of proper medical management of a patient's care.

In these guidelines, chapter III deals with the pre-admission phase of medical review and provides some general guides for the evaluation of need for skilled nursing home or mental hospital care. Chapters IV, V and VI deal with the second aspect of medical review: periodic on-site inspections of care by medical review teams.

The general guides to evaluation of need for care may also be useful to medical review teams in considering the possibility of alternative care arrangements being more appropriate in individual cases. However, they should be used in this context with caution and conservatism. Special consideration must be given in these cases to the possible effects of any changes in care arrangements on the health and functional status of the patients.

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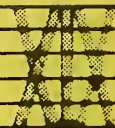
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5-60-20 Chapter I - Definitions**Chapter I****Definitions**

1. A Patient is an individual who is in need of and is receiving professional services directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health or alleviation of disease, disability or pain.
2. A Skilled Nursing Home Patient is a patient who is eligible for medical assistance under the title XIX State plan and who has been admitted to a skilled nursing home on recommendation of a physician and is receiving room, board, and professional services in the institution on a continuous 24-hour a day basis.
3. A Mental Hospital Patient is a patient, in a State where the title XIX State plan includes psychiatric care to the aged in hospitals for mental diseases, who is age 65 or older, is eligible for medical assistance under the title XIX State plan and has been admitted to a hospital for mental diseases on recommendation of a physician and is receiving room, board, and professional services in the institution on a continuous 24-hour a day basis.
4. Hospital Discharge Summary is a summary, in concise narrative form, of a patient's entire clinical and treatment profile while in a hospital. At the very least, it should identify the patient's chief complaint and primary reason for hospitalization; contain highlight of diagnostic and treatment modalities employed and details of pertinent findings and results; and summarize the patient's condition at the time of discharge, including specific instructions and recommendations to be followed in after-care. If the patient is being transferred to another health-care facility, such as a skilled nursing home, the discharge summary should clearly indicate primary and secondary diagnoses, and treatment orders to be followed upon admission to the second facility. It should contain sufficient clinical and other data to permit initiation of nursing care without interruption. However, such often is not the case; nor does the patient's hospital physician always continue on as his attending physician in the facility to which he is transferred; therefore: discharge summaries and transfer forms which may accompany medical assistance patients upon their admission to

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5-60-20 Chapter I - Definitions (continued)

a title XIX certified skilled nursing home or hospital for mental diseases usually are not adequate to fulfill the requirement of Section 250.23 (a)(1)(i) with respect to medical evaluation prior to such admission or prior to authorization of payments for skilled nursing home or mental hospital care.

5. Physician's Medical Evaluation, and Plan of Care is a physician's complete appraisal of the current clinical condition, diagnosis or diagnoses, and medical needs of the patient based upon a current physical examination^{1/}, recorded medical history, and where necessary, the patient's rehabilitation needs. It documents the type and range of care being recommended by him for the patient, and is prepared prior to admission to a skilled nursing home or mental hospital or prior to authorization of payment for care in such facilities.

The medical plan of care is the physician's specific treatment and medication orders and related therapeutic regimens that are to be followed in care of the patient, based on his medical evaluation. This medical plan of care also states treatment goals, estimates the prognosis and possible length of stay, and anticipates the probable kind of after-care that may be appropriate for meeting the patient's needs when his condition reaches a point where the care recommended initially no longer is necessary. The plan of care is in writing and a part of the patient's medical record.

6. Nursing Plan of Care is a program and plan for the provision of nursing and personal care. Good nursing practice calls for such a plan for each patient. It is prepared by the supervisory nurse, based upon admitting information provided, including the physician's orders and plan for medical care, together with informed observations of the patient and information elicited from him. It should include early and long-term nursing goals, and should be revised and up-dated at least weekly based upon treatment results and/or the patient's changing profile of needs.

^{1/} A "current" examination should be one that is recent enough to reflect the patient's present clinical condition, needs and treatment and not so dated that reliance upon it would be inconsistent with customary standards of good medical practice.

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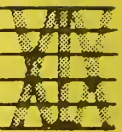
A well-structured nursing plan of care is the central core of information about the patient, containing a description of his specific and individualized needs and the best ways of meeting those needs. Optimal patient care can not be guaranteed by an adequate nursing care plan but can never be obtained without it.

7. Medical Review Team is a physician-supervised unit composed of one or more physicians and other appropriate health and social service personnel, responsible to the single State agency as employees, consultants, or contractors which provides periodic medical reviews and inspections in skilled nursing homes and hospitals for mental diseases approved by State agencies as providers of care for eligible medical assistance patients. It involves peer professional evaluations made by disciplines of like training and experience of the range, quality, adequacy and necessity of care and services being provided for individual medical assistance patients in skilled nursing homes and hospitals for mental diseases. Its most usual composition on skilled nursing home site visits is, one physician, one or more professional nurses, and one trained social worker; and for mental hospital site visits, one psychiatrist or a physician knowledgeable in the care of patients suffering from mental diseases, a psychiatric nurse and a social worker with training and/or experience in working with the mentally ill.

8. Utilization Review is a peer evaluation of quantitative and qualitative data reflected by or extracted from random or selective samplings of medical records of medical assistance patients. It involves analysis of samples of records for assessment of over or under use of treatment resources and professional services and the duration of stays with respect to those patients.

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Chapter II

Section-by-Section Interpretation of 45 CFR 250.23

This Chapter is intended to highlight the basic provisions of 45 CFR 250.23. The more significant interpretations are grouped by interrelated subject matter, and are dealt with in detail in Chapters III through VI.

(a) State plan requirements; medical review. A State plan for medical assistance under title XIX of the Social Security Act must:

(1) Provide, with respect to patients eligible under the State plan who are admitted to a skilled nursing home or who make application while in such a home, for a medical review (including medical evaluation) of the need for care in such a home, a written plan of care and, where applicable, a plan of rehabilitation; and if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases, provide, with respect to patients eligible under the State plan who are admitted to a mental hospital or who make application while in such a hospital, for a medical review (including medical evaluation) of the need for care in such a hospital, and a written plan of care. Such a review and plans would be made by the patient's attending physician with respect to care in skilled nursing homes, and by the attending physician or staff physician with respect to care in mental hospitals. Provisions required by this subparagraph shall include descriptions of methods and procedures to be followed in each case which assure that prior to admission or prior to authorization of payments, as may be appropriate:

Intent of this provision is to ensure that for each medical assistance patient seeking admission to a skilled nursing home or making application for title XIX benefits while in such home: (a) there is documentation by a physician of the clinical profile justifying the initial admission or continued placement in a skilled nursing home; (b) there are treatment orders and detailed instructions written by a physician covering the medical, nursing, nutritional, paramedical, personal, or restorative care and services to be provided and the estimated duration of need for such services; (c) there is a plan and procedure written by a physician for alternative care at a future point in time when the type of care initially recommended by him no longer is necessary; and (d) there is, where applicable, a plan of rehabilitation.

If a State provides medical assistance for persons 65 years of age or older when they are patients in mental hospitals, a psychiatric and social assay must be performed and recorded, in addition to requirements described in (a) through (c) above, for such persons upon their admission to the hospital or when they apply for title XIX benefits while in the hospital. The records should

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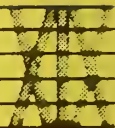
5-60-20 Chapter II - Section-by-Section Interpretation of 45 CFR 250.23
(Continued)

also show that the admissions were consonant with the laws governing admission to a public mental hospital in that State.

Ordinarily the single State agency would require receipt of the information outlined above prior to authorizing benefits.

In the interest of establishing a common standard of uniform information recording and reporting throughout the State, it is suggested that single State agencies consider the adoption of a check-off multi-copy "preadmission form." Such a form can encourage timely completion of medical evaluations by physicians, and promote consistency in the recording of pertinent identification information on persons applying for admission to or continuance of skilled nursing home or mental hospital care under title XIX. It can expedite analysis of the relationship between a physician's clinical findings and his recommendation that the patient be admitted for or continued on a skilled level of nursing care and services or for the patient's admission for or continuation under psychiatric care in a mental hospital. Also, its use can facilitate analysis and evaluation of the adequacy of physicians' orders and instructions covering the therapeutic, restorative, personal, or psychiatric care regimens to be followed; the reasonableness of physicians' estimates of patients' anticipated clinical or psychiatric course and probable

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long term expectancies and needs; and the examination of such other data as may be significant for the determination of patients' need for the kind of care recommended. Much of the information required by the single State agency for medical review purposes lends itself readily to check-off recording on a pre-structured form. A sample of such a medical evaluation form is presented as Exhibit I in Chapter VII.

(i) Each patient receives a complete medical evaluation which includes diagnoses, summary of present medical findings, medical history, mental and physical functional capacity, prognosis and an explicit recommendation by the physician with respect to admission to, or, in the case of persons who make application while inpatients in a skilled nursing home or mental hospital, continued care in, such skilled nursing home or mental hospital;

(ii) The plan of care includes orders for medications, treatments, restorative services, diet, special procedures recommended for the health and safety of the patient, activities, and plans for continuing care and discharge;

(iii) In the case of skilled nursing home patients, written reports of the evaluation and the written plan of care are delivered to the facility and entered in the patient's record at the time of admission or, in the case of patients already in the facility, immediately upon completion; and

(iv) In the case of patients in institutions for mental diseases, the evaluation also includes psychiatric and social evaluations;

These subsections elaborate basic content of that part of medical review which deals with preadmission evaluation as this is summarized in subparagraph (a)(1), above.

Subsection (a)(1)(i) describes what is to be covered by a physician's "medical evaluation" of medical assistance patients' need for skilled nursing home or mental hospital care. It calls for more than is customarily contained in the "history and physical" portion of a conventional medical record. Content of a standard "history and physical" usually is limited to recording of the patient's chief complaint; summarizing pertinent findings arising from examination of the patient's organic systems; appraisal of his vital signs and symptoms; review of relevant aspects of his past disease and illness profile; and statement of a primary diagnosis. By contrast, "medical evaluation" as the term is used here must: (a) include not only all of the elements of a standard

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(continued)

"history and physical," but also, significant physiological and related functional problems contributing to the patient's need for the skilled nursing and/or psychiatric care being recommended by the physician; and, (b) estimate the prospects and timing anticipated for improvement or other developments in the patient's condition which may require continuation of care of the kind recommended, or which may allow for his later transfer to an alternate arrangement for care more in accord with his needs as foreseen at a future point in time.

The mental hospital patient's record should show documentation of the following:

- (1) Essential information to identify the patient's emotional problems, diagnosis, and the precipitating circumstances leading to his admission to the hospital.
- (2) Psycho-social history and workup including the patient's background, onset, and development of illness.
- (3) Initial and ongoing discharge planning including such data as home conditions, family attitudes, and community resources.
- (4) Mental status examination which includes description of the patient's attitude and behavior, emotional status, mental content, and intellectual functioning.

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(5) Reports of medical history, physical examination, laboratory studies, consultations, psychological evaluation, dental records, reports of electroencephalograms, and other special studies if ordered.

(6) The treatment plan (plan of care) see (a)(i)(ii), including intercurrent diagnoses of any physical disease and plans for indicated treatment.

(7) Initial and subsequent psychiatric diagnoses recorded in the terminology of the American Psychiatric Association's Diagnostic and Statistical Manual #2.

Subsection (a)(1)(ii) specifies components of the plan of medical care upon which the physician must write definitive orders and instructions. The plan of care must specify what steps will be taken to place the patient in an alternative program of care suitable to his needs when his clinical, functional, and psychiatric status reaches a point where the care recommended initially no longer is necessary.

For patients in a mental hospital the plan of care should document prescribed treatment appropriate to the diagnoses and problems of the individual patient and should include such items as medications, psychotherapy, shock therapy, nursing care, social care, activities and rehabilitation, as may be indicated for the individual patient.

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Subsection (a)(1)(iii) underscores the necessity that the written reports required by subsections (a)(1)(i) and (a)(1)(ii) be prepared prior to admission and be entered in the skilled nursing home patient's record without delay.

Transfer forms which often accompany medical assistance patients upon their admission to a skilled nursing home following care and treatment in a short-term hospital usually are not adequate to meet the specific requirements for the physician's written medical evaluation, plan of care, and discharge programming, as these are defined in subsections (a)(1)(i) through (a)(1)(iv) above. Neither is the customary "discharge summary" copied from a hospital medical record usually acceptable as a substitute for a written medical evaluation and plan of care as these are described in sub-paragraph (a)(1) of Section 250.23 and its subsections.

Subsection (a)(i)(iv) requires that both a psychiatric and social assessment of mental hospital patients be made and recorded in addition to the clinical evaluations required by subsections (a)(1)(i) and (a)(1)(ii).

(2) Provide for periodic inspections to be made in all skilled nursing homes (and, if the State plan includes medical assistance for individuals 65 years of age and older in institutions for mental diseases, in each such institution) caring for patients under the plan by one or more medical review teams which shall

This subparagraph and those following relate to that part of the medical review program requirement dealing with periodic inspections by medical review teams. Periodic medical reviews are to be patient-centered rather than facility-centered.

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(i) Be composed of one or more physicians and other appropriate health and social service personnel; or in the case of teams reviewing care in mental institutions, one or more psychiatrists or physicians knowledgeable about mental institutions and other appropriate mental health and social service personnel;

(ii) Function under the supervision of a physician on the team;

(iii) Have no members who are employed by or have any financial interest in any nursing home (or, in the case of teams reviewing care in mental institutions, have a financial interest in any mental institution or are employed by a mental institution reviewed by the team of which they are members);

At least one physician must be a member of each medical review team, and he must be present and serve as team leader at on-site skilled nursing home and mental hospital inspectional reviews conducted at least annually.

Since the adequacy of nursing services is so basic to the provision of quality patient care in skilled nursing homes, "other appropriate health personnel" should be interpreted to mean at least one registered professional nurse as an essential member of each review team.

The requirement of other appropriate social service personnel in the membership of each review team may be met by utilizing the services of trained social workers employed by the single State agency itself, or by other agencies, public or private, under contract to it; social work employees of the State public assistance agency (when it is separate from the title XIX agency); or social work consultants to any such agencies.

Other medical and para-medical professionals who might be utilized as regular members, or who could be added to medical review teams on an ad hoc basis, include pharmacists, medical record librarians, physiotherapists, occupational and recreational therapists, speech therapists, dentists, and ophthalmologists. While constant use of such specialists may not be necessary, their participation along with regular members of review teams from time to

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time can help to orient the latter as to what to look for and how to deal with identified deficiencies in patient care factors falling within the purview of the specialists' disciplines.

At a minimum, composition of a review team for purposes of medical review inspections should be one physician, a registered professional nurse or nurses, and a trained social worker. For other visits to follow-up on review team findings registered nurses and/or social workers only might be adequate, with such persons reporting to the director of the medical review and inspection program of the State agency.

The review team for a mental hospital should be composed of a psychiatrist or physician knowledgeable about mental institutions and the treatment of mental patients and others experienced in the fields of psychiatric nursing, social work, and medical records. All members of the review team should have knowledge about the needs and treatment of over age 65 emotionally ill persons in mental hospitals.

Members of teams reviewing skilled nursing homes may not be employed by or have any financial interest in any nursing home. Members of teams reviewing mental institutions may not have a financial interest in any such institution and may not serve on a team which reviews a mental institution by which they are employed.

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5-60-20 Chapter II - Section-by-Section Interpretation of 45 CFR 250.23 (continued)

(3) Provide for methods and procedures which assure that:

This sub-paragraph spells out duties, restrictions and procedural aspects of functioning medical review and inspection teams.

Periodic medical reviews and inspections as required by this sub-paragraph are patient centered rather than facility-oriented. Hence, the medical review team need not concern itself with physical plant, environmental, or administrative or operational policies and practices except to the extent that they adversely affect the capability of the facility and its professional staff in rendering acceptable care.

The requirements of periodic medical review and inspections are not satisfied by "desk" evaluations and "paper" reviews by single State agency professional personnel conducted at their base of operations. Conditions and goals of medical review can be met only by on-site patient-care assessments and inspections conducted by properly constituted medical review teams in accordance with methods and procedures set forth in sub-paragraphs (a)(2) and (a)(3).

The fact that standards for patient care and services incorporated in and enforceable under licensure, certification or other programs of State agencies, may contain similar provisions is not to be construed as automatically meeting requirements. Periodic medical review and inspection processes must include every factor in Section 250.23 regardless of any collateral programs of official surveillance of the same provider facilities that may be in effect concurrently.

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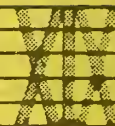
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Where a single State agency contracts with others to carry out on its behalf periodic medical review and inspections of the quality, range, and efficacy of care being provided for, and the appropriateness of placement of medical assistance patients in skilled nursing homes and mental hospitals, it is a duty of the single State agency to monitor the adequacy and effectiveness of performance under all such contracts.

(i) A sufficient number of teams exists and they are so distributed within the State that on-site inspections can be made in all skilled nursing homes (and mental institutions) caring for patients under the plan at appropriate intervals;

Following the first several medical reviews and inspections in a cross-section of small and large skilled nursing homes, and in provider facilities that are certified for both extended care under title XVIII and skilled nursing care under title XIX, and in one or more mental hospitals, patterns of problems encountered, time factors per patient review, and time required for pre-review orientation and exit conferences with facility administrative personnel will emerge. Such experience applied against the number of facilities to be covered, their title XIX patient populations, and their geographic dispersals, should make it possible to project the number of teams required to ensure at least one annual review and such interim reviews as circumstances require. Allowances must be made, of course, for time of team members required for post-inspection group conferences, advance planning, and necessary reporting, and follow-through on site visits.

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(ii) No physician member of a team inspects the care of patients for whom he is the attending physician;

Few, if any, conflict-of-interest problems anticipated by this subsection are likely to arise where review team physicians are full-time employees of the single State agency or of another public agency with which it may contract for the conduct of medical reviews and inspections.

Where a single State agency contracts with medical association foundations, group practice organizations, or individual private physicians to conduct, lead, and participate in medical reviews and inspections, possible conflict-of-interest difficulties could arise. In such cases the contract should incorporate the provisions of subdivisions (a)(2)(iii) and (a)(3)(ii) and the contractor should specify to the satisfaction of the single State agency the precautions to be taken to assure independent reviews.

(iii) At least one inspection by a medical review team is made in each skilled nursing home or mental institution within 1 year from the effective date of these regulations and thereafter at intervals to be determined by the team for each facility on the basis of consideration of the quality of care being rendered in the facility and the conditions of patients in the facility receiving service under the plan, but not less often than annually;

The language of this subsection clearly speaks for itself, i.e., all medical assistance patients in all title XIX skilled nursing homes and mental hospitals must be visited and observed. The adequacy of their physician, nursing, and para-medical care must be reviewed and evaluated at least once each year, and more often if major deficiencies in the foregoing respects are found on earlier inspections.

Since all mental hospitals providing care for payment under title XIX must be certified by title XVIII, the title XVIII survey agency should be notified if there are major deficiencies in the record keeping system of mental hospitals.

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(iv) No facility is notified of the time of an inspection more than 48 hours before the arrival of the medical review team; and

The intent is to ensure that review teams are exposed to the real-life day-to-day patterns of the facility's typical medical and nursing care practices and conditions, rather than artificially structured patterns of patient care hastily contrived for the sole purpose of "passing muster." This provision should not be interpreted as calling for 48 hours notice; rather as requiring pre-inspection notification to be held to the shortest practical time period, but in no case more than 48 hours. In cases of serious non-compliance or uncooperative attitudes on the part of individual facilities, unannounced inspections can be made at any time.

(v) The medical review team inspection includes for skilled nursing home patients personal contact with and observation of each patient receiving assistance under the plan by a team member or members, and review of each such patient's medical record, and for patients in mental institutions review of each such patient's medical record, if such record contains complete reports of periodic assessments required by section 1902(a)(20) of the Social Security Act, or if such reports are not available or are found to be inadequate, personal contact with and observation of each such patient. Such reviews and observations are to determine the adequacy of the services available to meet the current health needs and promote the optimal physical, mental, and psychosocial functioning of patients, the necessity and desirability of the continued placement of such patients in such facilities, and the feasibility of meeting their health needs through alternative institutional or non-institutional services. Under this requirement, such determinations may be based upon consideration of such items as whether:

Recommended specifics relative to precise duties of the medical review team members, and particular matters to be examined and evaluated by them are detailed in sub-parts (a) through (f) of this subsection. These are not exclusive and other items may be considered.

The importance attached to the requirement that a medical review team member or members must have personal contact with and make informed observations of each title XIX patient in skilled nursing homes and mental hospitals at least annually is underscored by its appearance in the opening sentence of this subsection. Attention is drawn also to the repetitive use of the words "each patient", which again stresses that personal contact with and observation of a sampling of patients does not satisfy the requirement.

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An exception to this is made for medical review of title XIX patients in mental hospitals where an evaluation of their medical records can suffice, provided medical records are not deficient in content of reports of patient assessments as required by section 1902(a)(20) of the Social Security Act, or are not lacking in other respects. The patient's record in mental hospitals should include the reports of the periodic review (1902 (a)(20)(B)) of the patient's treatment and need for continued treatment in the facility. This periodic review is required on a three-month basis for all mental hospital patients.

If the record does not include the reports of this periodic assessment and adequate documentation of the patient treatment and current status (including need for hospitalization), the review team should visit the patient care areas to:

- (1) Interview the patient care staff regarding the care of the patients, including medical treatment, nursing care, and documentation.
- (2) Observe the patient's manner of dress, activities, and the staff-patient interactions, and the daily living environment.
- (3) Discuss certain patients with the physician responsible for their treatment, and with other professional staff, including nurses, psychologists, occupational and physical therapists, rehabilitation staff, and others as indicated.

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(4) Interview the social work staff responsible for the patient's discharge planning including the hospital, family, and community involvement.

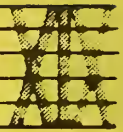
Only by direct contact with and professional observation of individual nursing home patients can judgments be made as to whether staff resources, nursing and personal care practices, therapeutic modalities, and treatment services are adequate to ensure that current needs of patients can be met; and that their physical and mental well-being and their psychosocial functioning are, in fact, being maintained at acceptable levels.

A further essential requirement is that of evaluating each patient's actual need for the kinds of care provided by the facility, and of determining whether an alternative care arrangement would meet his identified needs without prejudicing his physical and mental well-being or his physical and social functioning.

(a) The medical evaluation and plan of care for each patient are complete and current, the plan of care (and, where applicable, the plan of rehabilitation) is being followed and all services ordered (including dietary orders) are being rendered and properly recorded,

Examination of a patient's medical record will usually reveal whether his physician is duly attentive to alterations in his clinical and/or functional condition; and, if the physician's plan of care and treatment orders are revised accordingly.

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If restorative or maintenance physical therapy services are indicated, the physician should have written specific orders for exercises, range of motion manipulations, and other physical therapeutic services to be provided, and the orders should state if these are to be performed by nurses, attendants, or trained physiotherapists.

Similarly, if adjunctive services such as dental care, speech therapy, and optometric services are to be provided; or, if ancillary diagnostic testing such as laboratory, x-ray, electrocardiograph, or electroencephalograph are needed, timely orders should be written by the physician.

Whether or not physician care is appropriate and adequate in all of the foregoing respects can be determined post-facto by: (a) detailed professional observation and discussion with the patient; and, (b) equating impressions and findings arising therefrom with recorded information in his medical record reflecting frequency of physician visits, content of treatment orders, and quality of progress notes commensurate with the seriousness of his clinical problems and severity of his functional disabilities.

Examination of patients' medical records for completeness and quality of entries also will reveal whether a nursing plan of care for each patient has been written and is being followed; and if proper nursing notes are being made for each patient reflecting administration of medications, treatments, and therapies, and the patient's responses

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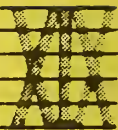
and progress arising therefrom. It will also reflect how diligent nursing and administrative personnel are in getting physicians to sign treatment orders given by telephone within 48 hours of their oral transmittal.

(b) Prescribed medications have been reviewed by the attending physician at least every 30 days, and tests or observations of patients indicated by their medication regimen have been made at appropriate times and properly recorded,

Medication regimens should be reviewed by the patients' physicians not less often than every 30 days, at which time the physician, on the basis of observation and/or physical examination of the patient and review of his medical record should: (a) re-authenticate any medication and/or treatment orders which he wishes to have continued, (b) write new orders for any changes to be made in the patient's medication and/or treatment program; (c) order such laboratory or other tests as may be indicated to check the efficacy or safety of the medication or treatment regimen being followed; and (d) write new orders as required by law for all dangerous and addictive drugs being administered. Any exception to the frequency of this practice should be justified by documentation in the patient's chart by the physician.

It is not necessarily incumbent upon medical review and inspection team members to communicate with private physicians of medical assistance patients respecting shortcomings in their modes of care of such patients. This is usually the role and function of the administrator or medical director of the provider facility concerned. However, it is possible under certain circumstances that

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the physician leader of the medical review team might wish to seek clarification from or to discuss purely medical aspects of care of individual patients with their attending physicians.

As a matter of good institutional practice, nursing homes and mental hospitals should remind physicians by mail or telephone of the due date for their next 30 day visit to given patients, and of their duties and obligations in that respect. After such notification, if a physician is unduly tardy in his response or refuses to visit the patient as required, it is the duty of the skilled nursing home to arrange for the patient to be seen and examined, and medication and treatment orders to be written or up-dated as appropriate by the facility's emergency physician or another.

(c) Physician, nurse, and other professional progress notes are made as required and appear to be consistent with the observed condition of the patient,

In addition to recording findings and writing required treatment, medication, and related orders, a patient's physician should also record any significant changes that may have occurred in the patient's condition between the time of his last and the current visit. If the patient's condition is unchanged, this should be noted by the physician.

Daily progress notes accurately and fully reflecting patients' current status, needs, and responses also must be made by nursing and paramedical therapists for all patients who are under active treatment and therapeutic regimens as well as for those whose clinical status is unstable.

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(d) Adequate services are being rendered each patient as evidenced by such observations as cleanliness, absence of decubiti, absence of signs of malnutrition or dehydration, and apparent maintenance of optimal physical, mental and psychosocial function,

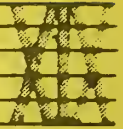
This determination cannot be made except by individualized bedside visits, close professional observation, and discreet interviewing of every title XIX patient by one or more members of the medical review and inspection team. A note reflecting bedside findings on each patient should be recorded by the member(s) of the review team. Spot checking or bedside visits to a sample of patients by the review team do not meet the intent or the specifics of this determination.

The one reliable way of determining whether the over-all physical status of each patient is being maintained at an optimum level through balanced nutritional and hydration support, and whether dutiful heed is being paid to his bodily hygiene, skin care, and oral health, is through informed observation and dialogue with each patient at the bedside by the physician and/or professional nurse member of the review team.

(e) The patient currently requires any service not available in or actually being furnished by the particular facility or through arrangements with others, and

Only by consolidating findings and impressions arising from carrying out such provisions as those of the above subdivisions (a)(b)(c) and (d), can members of the review team make rational collective judgments as to whether every title XIX patient is receiving all of the diagnostic, treatment, and adjunctive therapeutic care indicated by his condition and apparent progress. If needed services cannot be furnished by the facility, or if it cannot or will not make appropriate arrangements for the provision of required services

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by or through extramural health-care resources or personnel, the review team should recommend placement of the patient in a facility where needed care and services can be made available.

(f) Each patient actually needs continued placement in the facility or there is an appropriate plan to transfer the patient to an alternate method of care;

Similarly, the results of the considerations under subdivisions (a)(b)(c)(d) and (e) of this subparagraph should enable the medical review team to make a collective professional judgment with respect to each title XIX patient as to (a) the continued need for placement in the present facility; or (b) the feasibility of meeting his identified requirements through other institutional or noninstitutional arrangements commensurate with his evident and recorded clinical, treatment, therapeutic, personal, and psychosocial needs.

Discharge planning for each mental hospital patient should be documented in the patient's record and should show that the patient's right to treatment is given consideration and that the patient is included in the planning for alternative care. For example the patient should be allowed to participate, if able, in the choice of nursing home or intermediate care facility if such is the indicated alternative to mental hospital care.

The social service department should have an appropriate plan for communicating with the welfare case workers, public health nurses, and others who are involved in the aftercare and follow up programs in each county served by the hospital. There should also be an organized plan to prepare the patient to

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move into an alternate care facility and to prepare the facility staff to receive the new patient. There should be referral forms for reporting patient behaviorial and social information, and for the transfer of medication orders. The transfer plan should include planning for medical coverage after the patient leaves the hospital. The plan should include an arrangement for the transfer of a supply of drugs to treat the patient for a reasonable number of days in the alternate facility until further arrangements can be made.

(4) Provide for methods and procedures which assure that:

This sub-paragraph deals with the compilation and required channeling of formal reports on medical reviews and inspections.

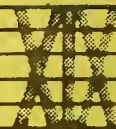
(1) A full and complete report on each inspection visit is promptly submitted by the medical review team to the single State agency covering the observations, conclusions and recommendations of the team with respect to the adequacy and quality of all patient services in the facility (including physician services to medical assistance patients in the facility) as well as specific findings with respect to individual patients;

A "full and complete report" of medical review teams within the intent of this subsection should reflect the findings on patient services as well as specific findings with respect to individual patients and contain as a minimum:

(1) The name, address, administrative officer, chief nurse, certification or participation number of the facility, and number of beds allocated or certified for care of medical assistance patients.

(2) Number of title XIX patients under care at the time of the inspection.

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(3) Name, address, medical assistance number, and other vital identification data on each title XIX patient observed and medically reviewed.

(4) Name and address of the attending physician of each medical assistance patient observed and medically reviewed.

(5) A simple report on title XIX patients whose care, treatment, physician visits and oversight, and current placement are consistent with and adequate for their identified needs.

(6) A detailed report on title XIX patients where specified aspects of care, treatment, physician visits and oversight is deficient, or where current placement is inappropriate, together with appropriate recommendations.

(7) A general report on the facility's capability for meeting appropriately the observed and recorded clinical, personal, functional, and psychosocial needs of title XIX patients.

(8) Notation of the adequacy of the facility's formal arrangements with extramural health-care resources for provision of adjunctive modalities and therapies, and ancillary diagnostic and treatment services of kinds not currently available in the provider facility.

(9) Notation of general impressions of attitudes, responsiveness, and cooperation of the administration of the provider facility in terms of assistance in expediting review processes; and reactions to comments, findings and recommendations presented orally during an "exit" conference at the conclusion of the review and inspection visit.

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(10) Notation of overview impressions of the facility in general, and its prevailing tone of professionalism, its social awareness and sensitivity, and its humanistic concern for the welfare and well-being of patients; and any recommendations for overall improvement of services.

The report of the medical review team for mental hospital patients should include:

(1) The name, address of hospital, certification number of the facility, and the number of beds certified for both titles XVIII and XIX patients.

(2) Number of title XIX patients under care at time of the medical review.

(3) Name of hospital superintendent, and the medical director, chief nurse, and chief social worker responsible for planning the care for these patients.

(4) A statement as to whether review was accomplished through review of records or through patient observation.

(5) A simple report as to the hospital's apparent capability for meeting the needs of the age 65 or over emotionally ill patient.

(6) A report of the areas of deficiencies, if any, in the active treatment program and nursing care.

(7) Brief report on the facility's plan for discharging patients to alternate long-term care facilities.

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(8) Summary of recommendations that will assist both the single State agency and the State mental health agency in improving the patient treatment and care program.

Use of tape recorders by review team members can be of help in speeding up inspections, and in ensuring that no significant findings are forgotten or overlooked for inclusion in summary finding and formal reports.

(ii) The single State agency forwards a copy of each inspection report both to the facility involved and its functioning utilization review committee, to the agency of the State responsible for licensure, and to the agencies responsible for certification or approval of the facilities involved for purposes of title XVIII or XIX, and to other agencies of the State which require the information in such reports in the performance of their official functions including, in the case of inspection reports on mental hospitals, the appropriate State mental health authorities, and

Copies of written reports incorporating findings and recommendations of medical review and inspectional teams made to the single State agency, are, in turn, to be distributed promptly by the single State agency to the provider facilities concerned and to their respective utilization review committees; as well as to the State agency responsible for facility licensure, agencies responsible for certification or approval of the facilities involved for purposes of titles XVIII and XIX, and to other State agencies that require the information in performance of their official functions including, in the case of inspection reports on mental hospitals, the appropriate State mental health authorities.

Where shortcomings are found with respect to physician care and surveillance of medical assistance patients in title XIX skilled nursing homes or mental hospitals; or, where transfer of a patient to alternative care is recommended by the medical review team, the State agency should also send a copy of the medical review team's adverse findings and/or recommendation for other placement to the attending physician of each patient concerned.

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(iii) Reports and recommendations are followed by appropriate action on the part of the single State agency.

Single State agencies should follow through promptly and consistently to monitor each facility's response to and compliance with recommendations made by medical review and inspection teams for change and improvement in respect to any aspect of care being provided medical assistance patients individually or collectively. Ordinarily this would be done through the agency of the State responsible, under arrangements with the title XIX agency, for facility survey and consultation functions.

If inadequacies in the attention to a patient by an attending physician are found and reported to the single State agency, the medical director of the single State agency should contact the attending physician and advise him of the reported deficiencies. An example might be a physician failing to visit a medical assistance patient in a skilled nursing home for an extended period. The patient's medical record does not contain justification for the infrequency of visits and shows only perfunctory notes by the physician. Upon receiving such information, the medical director of the single State agency would promptly notify the responsible physician of the reviewing physician's findings. If no favorable response is obtained, the medical director might properly report the situation to the local medical society.

If a patient is found by the review team to need services not available at the present facility, the single State agency should make arrangements for the provision of these services or transfer to a facility capable of providing them within a reasonable period of

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time. A "reasonable period" would depend upon the mental and physical conditions of the patient and the availability of alternate care.

Another example which should prompt action from the single State agency might be an elderly medical assistance patient who is unusually concerned about her immediate family or a close friend outside the facility. She has not been seen or visited in several months. The case worker supervisor of the local assistance agency should be contacted by the single State agency with a recommendation to investigate the case.

In the case of reports of reviews in mental hospitals, the coordinator of the mental health program within the single State agency should consult with the coordinator in the State mental health program and with the hospital superintendent and treatment staff regarding any reported deficiencies and recommendations from the medical review report. Together, a plan for correction of the deficiencies should be developed, and a reasonable time should be allowed for corrections to be made.

(b) *Coordination of utilization review and medical review.* (1) Periodic medical inspections by medical review teams as required by paragraph (a) of this section may be conducted by noninstitution based utilization review committees where the composition of such a committee meets the requirements of paragraph (a) (2) of this section, or is modified or supplemented to meet such requirements for purposes of its medical review activi-

If, under agreement with the State agency, functioning non-institution based utilization review committees undertake the conduct of periodic on-site medical reviews and inspections of medical assistance patients in skilled nursing homes or mental hospitals, they must: (a) supplement their utilization review physician complements by "other

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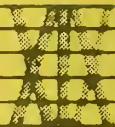
ties, and where such committee is willing and able to undertake in addition to its regular utilization review program the on-site inspection functions required by paragraph (a)(3) of this section.

appropriate health and social service personnel" which should include at the very least registered professional nurses and trained social workers; (b) meet all other requirements of sub-paragraph (a)(2) of Section 250.23 with respect to review team composition, organization, functions, and restrictions; and (c) be willing and able to carry out all of the duties and observe the restrictions of all of the provisions of sub-paragraph (a)(3) of Section 250.23. In the event that the mental hospital is using a Utilization Review Committee composed of non-State employed psychiatrists, psychiatric nurses, and social workers, their reports will meet the requirement for this medical review activity if:

- (1) all medical assistance patients are reviewed at least once yearly and reports are sufficiently inclusive to cover all requirements of the regulation;
- (2) the reports of each patient's review are included in the patient's record.

It might be said that medical review under Section 250.23 is an audit of sorts of utilization review of long-stay cases. In that sense, it is likely that the comprehensiveness of periodic medical review will serve the more limited purposes of utilization review committees to a greater degree than long-stay utilization review will serve the broader purposes of periodic medical review.

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(2) In the case of a facility which is not concurrently a provider of service under title XVIII of the Act, an inspection by a medical review team conducted according to the requirements of paragraph (a) of this section, whether or not performed by a utilization review committee as provided in subparagraph (1) of this paragraph (b), may, at the discretion of the single State agency, be considered to satisfy the requirement for utilization review of long-stay cases for the next regularly scheduled meeting of the utilization review committee.

This provision allows the single State agency the discretion of substituting, on a facility by facility basis, a medical review and inspectional visit and report for the next scheduled review by utilization review committees of long-stay medical assistance patients in skilled nursing homes which participate as providers under title XIX but not under title XVIII of the Social Security Act.

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**5-60-20 Chapter III - Appropriateness of Skilled Nursing Home and Mental
Hospital Care: Criteria of Medical Need and Feasible Alternatives**

Chapter III**Appropriateness of Skilled Nursing Home and Mental Hospital
Care: Criteria of Medical Need and Feasible Alternatives**

The physical well-being and personal welfare of long-term patients should be the prime concern of those who make determinations as to the adequacy, appropriateness and timeliness of institutional care and treatment being rendered in relation to the identified needs of such patients at various stages in their episodes of sickness, diseases or functional disability.

Standardized criteria for relating with reasonable exactness the needs of individual patients at given points in the progression of their afflictions and the capability of particular facilities to meet those needs are not yet available. Nevertheless, experienced professionals in various disciplines of healing arts can make perceptive and highly reliable value judgments within the range of their expertise, both about patients and about health-care facilities.

In this chapter, typical clinical criteria for evaluating the needs of medical assistance patients seeking admission to and continuation of care in skilled nursing homes and mental hospitals, and representative profiles of medical and nursing care needs characterizing such patients are examined. Types of situations that do not ordinarily call for skilled nursing home and mental hospital care are also indicated. Examples given are not all-inclusive, and are intended only as illustrations of some of the many variables and typical judgmental situations that are likely to be encountered in the evaluation of need for skilled nursing home or mental hospital care. While the initial focus is on the physicians' decision to admit patients to the facilities, the same criteria are applicable in the medical review team's appraisal of the need for continued care in those facilities.

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The chapter concludes with reference to the suggested standardized medical evaluation form for use by attending physicians, a brief description of alternatives to skilled nursing home and mental hospital care, and the relationship between evaluation of medical need, feasible alternatives, and the State agency's authorization of payment for care.

Skilled Nursing Home Care

Criteria of Medical Need - In general, a physician should refer a patient to a skilled nursing facility when in his judgment the patient requires skilled nursing services, but does not require the constant availability of the medical services of an acute hospital. Skilled nursing services are those which must be furnished by or under the direct supervision of licensed nursing personnel, and under the general direction of a physician in order to assure the safety of the patient and to achieve the medically desired results. The critical factor in distinguishing skilled from unskilled or supportive care is the need for the services of licensed health personnel.

If the physician determines that the patient requires any one or more of the following, skilled nursing home care is appropriate:

- (1) Observation by a registered professional nurse, or a licensed practical nurse, at least once daily, and assessment of the total needs of the patient by such personnel.
- (2) A treatment plan involving the planning and administration of multiple services prescribed by the physician.
- (3) Continuous availability of nursing personnel at the level of a licensed practical nurse or higher.
- (4) Administration and/or control of medications required by State law to be the exclusive responsibility of registered or licensed nurses and any other specific services subject to such limitations under the State nurse practice act.

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(5) Continuing medical and nursing care of sufficient degree to necessitate the maintenance of a continuing clinical record by the institution.

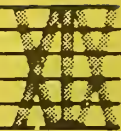
(6) Performance of any direct services that the physician judges can be provided safely only by

- (a) a registered professional nurse; or
- (b) a licensed practical nurse; or
- (c) other personnel working under the direction of a professional or licensed practical nurse.

A patient whose needs can generally be met by unskilled services may, because of special considerations in an individual case, require their performance under skilled supervision or observation. In such situations, however, the complications or special considerations involved should be documented by nursing notes and/or physician orders and/or progress notes. These records should include observations on physical findings, new developments in the course of the disease, and the details of carrying out the services prescribed.

The determining factor as to whether skilled nursing home services are required or the needs can be met in a lesser care facility is the type of care required, not primarily the amount of the care. Many elderly and infirm people need large amounts of attention and care but require only services that can be given by persons with little or no training in nursing. Their needs usually can be met in facilities covered by the intermediate care classification. On the other hand, many persons suffer from chronic diseases that necessitate kinds of treatment and care that require frequent or continuous observation and/or specialized services that can safely be performed for them only by, or under the supervision of, professional or licensed practical nurses. The total amount of time required in caring for these patients often is no greater than that needed by individuals in intermediate care facilities and, in individual instances, it may actually be less. The difference is in the kind of service required.

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5-60-20 Chapter III - Appropriateness of Skilled Nursing Home and Mental Hospital Care: Criteria of Medical Need and Feasible Alternatives (continued)

The following examples of conditions indicating need for skilled care or unskilled services are intended to provide a general framework for the exercise of professional judgment. They cannot be used in a check list fashion or as rigid criteria for approving or denying access to skilled nursing home care. While general criteria which are illustrative of skilled nursing home cases and cases for which skilled nursing home admission is not appropriate can be written, there is no substitute for professional judgment applied to individual cases following a thorough assessment of a patient's conditions and needs and the resources available to respond constructively to his needs.

Examples of Skilled Nursing Home Care

(a) Skilled Observations and Assessments: As suggested by the first criterion above, it is often medically reasonable to admit patients to a skilled nursing home mainly for purposes of continuous observation and assessment, by skilled professionals, of a medical disease or postoperative condition. Approval for such admissions should not be of unlimited duration, however; and the physician's plan of care should specify the estimated period required for such assessment. Clinical conditions which might qualify patients for admission for continuous skilled nursing observation could include: unregulated diabetes mellitus where frequent urinalysis and changes in diet and medication are required; coronary artery ischemia, and other heart disease problems such as severe arteriosclerosis or atrial fibrillation where patients require close watching for signs of decompensation, maintenance of proper fluid balance, frequent recording of vital signs, and attentive regulation of medication which might have undesirable side-effects; respiratory insufficiency requiring prompt adjustments in medication and therapy; and mental and behavioral patterns requiring the administration of psychotropic medications; catatonia, organic brain syndrome and other mental conditions where skilled observation is required to detect and respond to changes in the patient's needs and to promote optimal psychosocial and physical functioning.

There must be full written justification by the admitting physician when skilled nursing home patient observation is recommended. Also, the continued need for skilled and continuous observation must be fully documented by

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nursing notes and physician progress records. Medical review teams must be especially vigilant when evaluating the continued care of patients who are admitted primarily for observation.

(b) Skilled Nursing Services

Following are examples of kinds of direct services that can be administered safely only by, or under the direct supervision of, skilled nursing personnel (criterion (6) above) and are commonly furnished in skilled nursing homes. Eligible medical assistance patients are entitled to the benefits of these and similar kinds of skilled care when they are provided in a skilled nursing home approved for participation under a title XIX State plan.

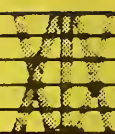
(1) Administration of Medication: Medications given by intravenous or intramuscular injections usually require skilled services. (However, intramuscular injections required once or twice a week, or injections which can usually be self-administered, such as daily insulin for well-regulated diabetics would not necessarily require admission to a skilled nursing home.) Oral medication which may require immediate dosage change because of sudden undesirable side effects or serious reactions should be administered by or under observation of licensed nurses, and hence, is a skilled service. Where a prolonged regimen or oral drug therapy is instituted, the need for continued presence of skilled nursing personnel is justified only during the period in which the routine is being established when changes in dosage require professional judgments not possessed by unskilled persons.

(2) Intravenous Feeding, and Clysis: Intravenous feedings and hypodermoclysis are considered to be skilled care.

(3) Levine Tube and Gastrostomy Feedings: These feedings must be properly prepared and administered. Both require supervision and observation by licensed nurses.

(4) Nasopharyngeal Aspiration and Tracheostomy Care: The services and observation required for such care constitute skilled nursing.

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(5) Colostomy or Ileostomy Care: Skilled service is usually required during the immediate postoperative period following a newly created or revised opening. General continuous maintenance care of this condition can usually be performed by the patient himself or by a person without professional training and usually does not require continuing skilled care.

(6) Catheterizations: Repeated catheterizations during the immediate postoperative period following abdominal surgery constitute skilled nursing care. This is especially so with early postoperative prostatectomy patients when the risk of hemorrhage and infection is high. Catheters used in other parts of the body, such as bile ducts, chest cavity, etc., require skilled care.

(7) Incontinence: Secondary skin problems resulting from incontinence often require special treatment calling for professional nursing skills. Physicians' orders must indicate the specific treatment required in such instances.

(8) Skin Care: Existence of extensive decubitus ulcers, or other widespread skin disorders usually necessitates skilled care. Physicians' orders for treating the skin and/or decubitus ulcers, rather than diagnosis, would be the principal indicator as to whether skilled care is required.

(9) Dressings: Special care in connection with application of physician prescribed dressings involving prescription medications carried out under aseptic techniques constitute skilled services. Ileostomy or colostomy patients may well require such care in early postoperative periods.

(10) Administration of Medical Gas: Regimens involving the regular administration of medical gases would be instituted only upon specific physician orders. The initial phases of such a regimen require skilled care. However, when such administration becomes regular routine, it would not generally be considered a skilled service since most patients can be taught to operate their own inhalation equipment, or nonskilled personnel can supervise its administration, as in cases of chronic asthma, emphysema, etc.

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(11) Plaster casts: The presence of a cast does not necessarily establish the need for skilled services. If, however, the attending physician's orders reflect a need for special care or observation by nurses, the care should be skilled.

(12) Heat treatment: Heat treatment furnished by a nurse and specifically ordered by the attending physician as part of active treatment which requires observation by skilled personnel to adequately evaluate the patient's progress would be considered skilled services.

(13) Restorative nursing procedures: Such procedures, including the related teaching and adaptive aspects of skilled nursing, would be considered skilled services when they are part of active treatment and the presence of licensed nurses at the time they are performed is required.

(c) Unskilled Nursing Service

The following are examples of kinds of care and services which, by themselves, or even in some combinations, would not necessarily justify admission of a medical assistance patient to or continued care in a skilled nursing home approved for participation under a title XIX State plan.

(1) Sociological factors, or inadequacies or stresses in the domestic setting of a medical assistance patient, do not alone justify his admission, care, or prolongation of stay in a skilled nursing home.

(2) A patient's need for intramuscular injections once or twice a week would rarely justify his care in a skilled nursing home, unless such need were accompanied by other nursing needs requiring skilled care on a continuous basis. The use of a visiting nurse, a home health agency or an out-patient clinic would be a more appropriate arrangement for this limited need.

(3) Administration of oral medications to a patient too senile or too physically incapacitated to perform the act himself is not a service that necessarily calls for a licensed nurse.

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(4) If the primary need of an incapacitated nonambulatory patient is for frequent changes in body position to avoid development of decubiti, this would not by itself call for the skills of licensed nursing personnel.

(5) Maintenance colostomy or ileostomy care can usually be performed by patients for themselves or by nonprofessional persons after appropriate instruction.

(6) The presence of superficial decubiti or other inflammation requiring palliative skin care with medicated creams and topical ointments does not call for skilled care.

(7) Routine change of surgical dressings on non-infected wounds, or routine care of long-term chronic conditions, can be performed by non-skilled persons.

(8) The presence of a cast over any part of a patient's body, or the use of braces and similar devices do not require skilled nursing care for their routine maintenance; nor would the use of protective restraints such as bed rails, body supports and harnesses require the services of skilled personnel. If any special care in connection with the application or use of any such items calls for professional skills, justification for the same must be documented by the attending physician in the patient's medical record.

(9) Intermittent administration of medical gases for patients whose medical need for the same has stabilized does not require skilled care.

(10) Physical therapy performed by a licensed physiotherapist, although a professional adjunctive service which should be made available to patients by skilled nursing homes when ordered by their physicians, is not itself considered to call for skilled nursing care.

(11) Supervision, training, and assistance in activities of daily living can be performed by non-skilled persons.'

When any of the following circumstances exist, the patient must have, in addition, a condition which concurrently requires active skilled nursing care to justify admission and continued care in a skilled nursing home:

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- (1) The patient is capable of independent ambulation and personal care.
- (2) The admission and stay is for uncomplicated postoperative care.
- (3) The diagnosis is so non-specific as not to indicate a particular need for definitive skilled nursing care, for example, "chronic brain syndrome", "senility", "old CVA", "chronic arteriosclerosis", "blind", "in pain", "dizziness."

It should be emphasized again that the presence primarily of conditions such as those listed above would not necessarily preclude a valid judgment that a skilled nursing home is the appropriate site of care. There may be circumstances in which the services required, while within the ability of unskilled persons, should be rendered under the supervision of a licensed nurse and the overall care and progress of the patient should be subject to skilled observation.

Mental Hospital Care

In those States providing mental hospital services for Medicaid recipients, patients must be 65 years of age or older, and must require continuous and active inpatient psychiatric treatment and care for organic mental disease or severe mental impairments in a facility where such treatment and care

- Is provided pursuant to a documented psychiatric evaluation, diagnosis, and individualized plan of care made by a qualified psychiatrist for each patient.
- Is continuously directed and evaluated by a trained psychiatrist.
- Requires skilled psychiatric nursing services calling for specialized training beyond that usually included in professional nursing curricula.
- Includes on-going medical and social evaluations to determine at what point a patient's progress has reached the stage where his needs can be met appropriately and adequately outside of the institution, and

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- May be accompanied by concurrent medical conditions that call for care and services of kinds usually furnished in skilled nursing homes or general hospitals.

Criteria of Medical Need

Criteria for admission and continuing care in mental hospitals vary widely among the hospitals and political jurisdictions. This absence of uniform criteria hampers the definition and description of parameters of mental hospital care specific to medical assistance patients aged 65 and older. Nonetheless, it is possible to generalize by indicating the kinds of institutional psychiatric care needed by various types of mentally ill upper-age patients that most specialists in the field of mental health probably would accept as being "clearly appropriate" or "clearly inappropriate."

(a) Clearly Appropriate Care For:

- (1) Patients with functional psychoses without significant concurrent illness or disability for whom general hospital care or ambulatory treatment is not feasible.
- (2) Patients with acute or chronic psychiatric illness, such as schizophrenia or severe depression, who require 24-hour care for diagnostic evaluation and psychiatric treatment.
- (3) Patients receiving psychiatric treatment in the community who require brief periods of protection from the consequences of their behavior during episodes of acute disturbance or depression, e.g., suicide, homicide, spending sprees, or refusal to eat during episodes of acute disturbance or depression.
- (4) Patients with chronic mental illness who require protection and management, as well as treatment, during periods of disruptive or disorganized behavior requiring regular and frequent attendance of a physician.

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- (5) Patients diagnosed as alcoholics, who do not have concurrently any significant physical illness, and whose disability, following detoxification, requires a period of inpatient treatment specifically for underlying causes of their alcoholism.
 - (6) Patients with severe organic brain disease whose usual behavior is unresponsive to medication, and is too disturbing to be managed at home or in another facility, such as: the physically aggressive patient, the fire setter, or person otherwise dangerous to himself or others when physically capable of destructive behavior.
 - (7) Patients who during episodes of agitation and restlessness produced by a stress situation may require brief mental hospital treatment.
 - (8) Patients with moderate or advanced psychiatric symptoms who require careful evaluation of their potential for improvement; and who, when home factors are detrimental, may require assessment in the controlled environment of a mental hospital.
- (b) Clearly Inappropriate Care For:
- (1) Persons with major medical problems and minor mental symptoms, such as patients who become mildly confused or disturbed as a result of or in conjunction with a recent head injury, cardiovascular disease, diabetes, metabolic disturbance, terminal malignance, or for whom psychiatric consultation might be utilized rather than mental hospital admission.
 - (2) Persons with inconsequential lapses of memory and mild disorientation as a result of chronic brain syndrome, who are more effectively treated or managed in their own homes, or in a foster home, home for the aged, etc., and for whom a mental hospital has little to offer, and indeed, might even aggravate their confusion.

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- (3) Persons who need only adequate living accommodations or economic or other social support services to relieve their psychic stresses.

(c) Individualized Assessments

Various factors have to be weighed to determine the course of action best suited to an individual patient's needs. When doubt exists as to the etiology of the patient's behavioral disturbance, or if he is suffering concurrently from a physical ailment more severe than the mental disorder, admission to a mental hospital should be deferred until a total medical evaluation can be made.

Family members and referring physicians of medical assistance patients in mental hospitals should bear in mind that such patients may remain in a mental hospital only so long as is psychiatrically indicated; or only as long as such hospitalization can be expected to benefit them by effecting clinical recovery or significant symptomatic improvement.

Medical Evaluation Form

In making his medical evaluation of skilled nursing home patients, employing the foregoing criteria, the physician is required by 45 CFR 250.23(a)(1)(iii) to prepare a written report (along with the written plan of care) for delivery to the facility and entry in the patient's record.

Physicians are notoriously reluctant when it comes to "paper work" relative to their professional activities. Therefore, to the extent that this responsibility is made easier for them, the possibilities of it being done promptly, fully, and willingly, are enhanced. Also, the degree to which uniformity in recording and reporting of required clinical and related information by all physicians in a jurisdiction can be brought about will simplify and speed-up evaluations related to both official agency authorizations for care, and official medical reviews of care. With that end in view, a check-off type MEDICAL EVALUATION FORM incorporating essential information required of physicians--such as medical history and physical examination findings, admission recommendation, initial treatment

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and medication orders, plan of care, and prognosis--is suggested for adoption or adaptation by medical assistance agencies. A sample MEDICAL EVALUATION FORM is presented as Exhibit I in Chapter VII.

Use of such a comprehensive, standardized form can offer many advantages and save many manhours for assistance agencies and for the medical review and inspection program of the State agency, so that serious consideration should be given to providing supplies of these forms at no cost to participating physicians.

This kind of check-off recording and reporting aid should be printed as a multi-carbon, snap-out, one-time-use form with as many copies as may be needed for all concerned parties, including but not necessarily limited to:

- The attending physician
- The provider facility
- The appropriate local and State public assistance offices
- The single State agency.

Alternatives to Skilled Nursing Home and Mental Hospital Care

Prior to admission, or to authorization of payment when the patient applies for assistance while already in a facility, the physician makes his determination of the need for care in the skilled nursing home or mental hospital. A factor that should be considered at this point is the feasibility of meeting the patient's health needs through alternative institutional or non-institutional services.

Similarly, when conditions of patients who have been receiving care in skilled nursing homes or mental hospitals have reached a point where the kinds of care afforded by these institutions are no longer necessary or appropriate, professional staff, including the attending physicians, must be alert to initiate action to transfer such patients to other facilities or modes of care more compatible with their identified medical, nursing, and personal needs.

In some instances, the alternative could be the more intensive complex of care and services of an acute, short-term general hospital. However, most frequently it will mean alternative kinds of medical, nursing, and personal care that are less active, less intensive, less skilled, less

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continuous, and more oriented to meeting patients' needs for protective living arrangements and personal services, along with a maintenance level of intermittent medical and nursing care more appropriate to their needs.

One of the functions of periodic medical review programs is to check on the feasibility of meeting the patient's health needs through alternative services.

Kinds of care which are usually available as alternatives to skilled nursing home and mental hospital care include intermediate care, residential care, day care, outpatient clinic services, home health care and visiting nurse services.

Evaluation of Need, Feasible Alternatives, and Payment for Care

To conclude this chapter, it is worth noting the critical relationship between the evaluation of the need for skilled nursing home or mental hospital care and the availability of feasible alternatives, on one hand, and the State agency's authority to claim Federal matching for such care, on the other. In order for the agency to make such a claim, there must be available in its files a record showing clearly a physician's recommendation that the patient be given skilled nursing home or mental hospital care. In addition, there must be available in the case file a record establishing that the agency staff has evaluated all reasonable possibilities for meeting the patient's needs through alternative institutional or non-institutional services.

When patients remain in the facilities for extended periods of time, the case record should also show that re-evaluations of both points have been made at periodic intervals.

The medical evaluation must be made by the physician employing criteria such as those described above. The availability of alternate arrangements for care of the patient usually is determined by the agency caseworker. The State agency's final decision as to where the patient is to receive care should be based upon consideration of both these factors.

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Comments****Chapter IV****Periodic Medical Review and Inspection: General Comments**

The remaining three chapters focus on the second type of medical review process required by the statute and regulation: periodic medical review and medical inspection. It describes differing approaches that might be taken by title XIX single State agencies toward implementation of this requirement. It examines features of some medical review methods that have proven effective in a few jurisdictions; presents ideas and suggestion for the structuring and conduct of medical review programs; discusses the intent and implications of various components of the medical review process; proposes concepts and procedural mechanisms that might lend themselves to adoption or adaptation; and presents a number of aids that may be found of practical value in initiating, sustaining, or improving medical review structures, and in carrying out routine activities and actions called for under the regulation.

Periodic medical review is complex, demanding, and time-consuming. There is no one path leading to achievement of its program objectives. Differences in operational patterns, size, and location of skilled nursing homes and mental hospitals, and variables in medical and related health manpower and facility resources among communities, regions, and States will give rise to a variety of functional forms of medical review.

The primary goal of periodic medical review is to ensure the provision of a range and quality of medical and nursing management and social work support for title XIX skilled nursing home and mental hospital patients that is both necessary and commensurate with their clinical and physical needs and optimum social functioning. In that context, the three groups most critical to the well-being of individual patients are the physicians, nurses, and case workers who serve them. Appraisal of how well each of these is responding separately and in relation to each other, in providing quality care that is timely and conforms to acceptable standards and practices in meeting the over-all needs of individual medical assistance patients, is the key aim of the patient-centered medical, nursing, and social evaluations required by the regulation.

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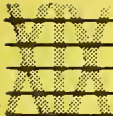
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A secondary goal of periodic medical review is to match the kinds and degrees of physician, nursing, and personal services actually needed by the patients with facilities most able to render such care, i.e., to make certain that the kind of care offered by a title XIX certified skilled nursing home or mental hospital is, in fact, necessary to meeting the current medical, nursing, personal or psychiatric needs of individual patients; and if not, to recommend and initiate action for transfer of such patients to alternative and more appropriate arrangements.

Periodic medical review does not embrace certification of medical assistance patients for skilled nursing home or mental hospital care, covered in chapter III. However, evaluation of the adequacy of recorded medical and social information provided at the time of admission of medical assistance patients in accord with requirements of 45 CFR 250.23 is an essential component of the periodic medical review and inspection process.

Periodic medical review entails the making of professional, not administrative judgments, by review team members, individually and collectively. Team members must be alert to and concerned with deficiencies in facility environments, resources, and staffing patterns to the extent that these bear on the well-being and safety of patients or detract from effectiveness of medical or nursing care. However, it is not the intention of the regulation that time and effort available for professional aspects of the medical review process be dissipated by preoccupation with facility factors falling within the roles of other governmental licensing, approval, and certifying agencies.

Periodic medical review is not to be construed as supplanting or replacing utilization review as required by section 1902(a)(30) and 45 CFR 250.20. Rather, it supplements and provides a form of audit as to the effectiveness of long-stay utilization review conducted by utilization review committees. Utilization review usually is limited to random samplings of in-house and discharged long-stay patients; whereas, medical review applies to every in-house medical assistance patient, regardless of when admitted. Utilization review concerns itself with the range and quality of care mainly to ascertain whether such care is appropriate to the needs of the patient. Periodic medical review, on the other hand, being both medically and socially oriented, has as its primary objective the upgrading of the quality of physician, nursing, personal, and social services being rendered in provider facilities; and elevating the clinical and physical status and social



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functioning of medical assistance patients receiving care in such facilities. Individualized patient evaluations incident to achieving that primary objective create a base upon which medical review teams are enabled to make valid judgments as to the feasibility of using alternative kinds of care when active skilled nursing home or mental hospital psychiatric care is no longer necessary.

A by-product of periodic medical review is its beneficial influence in raising the professional tone and improving overall standards of care for all other patients in the same facilities.

Suggested medical review structures, procedural formats and other criteria contained herein should not be considered or applied as rules and regulations; neither are they represented as being all-inclusive. Rather, they are offered as reasonable and practical guidelines for use by single State agencies in developing effective medical review and inspectional structures and procedures, or in applying or adapting constructively for refinement of programs that are already in operation.

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Chapter V

Medical Review Inspectional Structures and Relationships

This Chapter examines and discusses various options that are open to single State agencies for the structuring of program mechanisms for carrying into effect the requirements of periodic medical review and inspections under the regulation.

Medical Review Team Composition

As indicated earlier, the usual basic composition of medical review teams and the professional disciplines most commonly utilized to advantage as consultants are as follows:

Basic Team Members*

- One licensed physician
- One or more registered professional nurses
- One professional social worker

Professional Consultants

- Licensed pharmacist
- Registered medical records librarian
- Registered physiotherapist
- Trained occupational or recreational therapist
- Trained speech therapist and/or audiologist
- Licensed dentist
- Licensed podiatrist
- Licensed psychiatrist
- Licensed ophthalmologist or optometrist
- Registered dietitian or nutritionist
- Trained health facility administrator

*For medical reviews and inspections of medical assistance patients receiving care in hospitals for mental diseases, it is necessary that the basic medical review team include a psychiatrist or physician familiar with treatment of mental diseases; and if possible, professional nurses with training and experience in psychiatric nursing, and social workers with training and experience in psychiatric social work.

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(continued)Support Personnel

Competent secretarial and clerical support of the medical review and inspection program will be essential because of its technical and confidential nature, and the volume and complexity of paper work entailed in scheduling and coordinating inspections, preparing and distributing review reports and recommendations, preparing follow-up correspondence on site visits, and processing reports by review teams. In States having a large volume of medical assistance patients and a great number of provider facilities, appointment of a full-time coordinator-supervisor for the total program may be indicated. Such an executive should be experienced in long-term health care administration; or be thoroughly familiar with the nature and content of chronic disease care, as well as understanding the organization and operations of long-term health care facilities.

Physician Team Leader Role

The physician member of a medical review team is its director, programmer, and coordinator; and is the final authority for its medical findings, patient-care recommendations, and official actions. He must be present and participate in at least one annual on-site review and inspection of each skilled nursing home or mental hospital assigned to his team. His special function is to review and assess the physician services and the medical management of each patient's case by attending physicians. His general responsibility is the supervision of the review team's visit to assure that observations are sufficient to make the necessary judgments about the quality of care for each patient.

Nurse Team Member Role

The professional nurse member(s) of a medical review team examines medical records of all medical assistance patients to appraise: (a) appropriateness of placement from a nursing care standpoint; (b) sufficiency of written plans for nursing and personal care, and adequacy of follow-through in accord with such plans; (c) unmet nursing care and personal care needs of patients, the general clinical profile and physical status of patients, and the apparent response of patients to care and treatment based upon bedside observations; (d) the accuracy, completeness and currency of nursing, treatment, and progress notes in patients' medical records; (e) the

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nutritional and hydrational status of each patient, and appropriateness of his dietary regimen; and (f) other observations related to patient-care.

Social Service Team Member Role

The social services member of the team must have a thorough knowledge of the public assistance aspects of title XIX in the State. This should include professional knowledge of eligibility aspects and the State's provision for social services to adult recipients, if any, as well as professional knowledge of the social factors in illness. This person also has a responsibility to work closely with the State's specialists on social services when the State provides these services.

When the responsibility for medical review rests with an agency other than the title I agency, and the former agency is not staffed with appropriate social service personnel, it may be desirable to contract with the title I agency for competent staff.

Social service members of medical review teams may be employees of the single State agency, or may serve on review teams by arrangement between the single State agency or its contractor and any recognized public or private social service agency. However, the social service member should not be a regular employee of the local assistance agency since the role of this team member is in part an evaluation of the work of that agency.

Concurrently with on-site medical and nursing care reviews, the social service member of the team will examine pertinent medical and social welfare records of medical assistance patients in both the responsible public assistance office and the facility and will review the record of the social evaluation of need for care and appropriateness of placement in the skilled nursing home, including consideration of alternate means of meeting the patient's needs, and the record of subsequent contacts with the patient by the agency worker. This team member will interview and observe patients to assay their attitudes toward their present placement and care; their needs for special services not being provided; the availability and appropriateness of diversionary activity and recreational resources and programs in the provider facility, etc.

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(continued)

The social work member also will participate in medical review team conferences; and will provide liaison with welfare departments and others in arranging for necessary social services and related support of patients as indicated.

Role of Consultants

Consultants to basic medical review teams representative of the disciplines named earlier in this Chapter might be utilized only occasionally. On the other hand, however, selective participation of such specialists in scheduled medical reviews and inspections might be desirable. If a selected consultant could accompany the medical review teams on each on-site inspection, regular members of review teams would benefit from practical orientation to nuances of the particular specialty, and patients would benefit accordingly. Maximum flexibility in setting up protocols for most effective participation of the consultants under differing circumstances would be necessary on the part of the physician team leader. Consultants would not be expected to make formal reports or independent evaluations. They would observe and evaluate selected patients as directed by the physician leader, or on request of the nurse team member. In most instances, they would probably accompany the nurse member on her rounds making pertinent observations and recommendations as they go.

Inter-agency Contractual Arrangements

Some single State agencies may wish to contract the medical review task to other State agencies. Such an arrangement may offer the advantage of placing the day-to-day mechanics of the reviews in experienced professional hands in units that have familiarity and formal relationships with the provider facilities concerned. Almost without exception such an arrangement would be made with the State health and/or mental health agency. It should be effected through a contract that spells out in detail the joint duties, obligations, fiscal arrangements, and other mutual commitments of the contracting parties.

Where the State health agency is, in fact, the official single State agency for administration of the title XIX State plan, or has assumed responsibility for periodic medical reviews and inspections under contract with the single State agency, it may, in turn, sub-contract for performance of some or all of the duties by local or regional health units. In States with widely dispersed populations, or conversely, where there are large population concentrations, such sub-contracting could have practical advantages.

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Regardless of the form and degree of delegation of review functions and division of labor, however, the single State agency will remain responsible for the full and effective implementation of medical reviews and inspections under the regulation and for taking appropriate action on the reports and recommendations of the review teams.

Contracts with Private Professional Groups

In many States, resources other than State or local public agencies may be available for the conduct of periodic medical review. State agencies are encouraged to explore possibilities within the State for utilizing special resources in particular geographic areas. Single State agencies may wish to adopt two or more kinds of arrangements in different localities within the State to compare and evaluate their effectiveness.

In response to a number of social concerns and public-interest pressures, a marked upsurge is taking place in the formation and expansion of physician, community, or corporation sponsored capitation prepayment health-care insurance plans for the purpose of providing ready access to comprehensive health services for enrollees covered by the plans. The two most significant such developments are foundations for medical care and health maintenance organizations. Characteristics of each, and the possible roles that conceivably might be played by either or both in the implementation of periodic medical reviews and inspections on behalf of and under contract with single State agencies, are set forth below:

Foundations for Medical Care

Foundations for medical care are autonomous corporations sponsored and wholly owned by State or county medical societies to carry on a variety of activities, the principal one of which is promoting the improvement and expansion of comprehensive health-care delivery through prepayment insurance plans wherein benefit standards and structures, utilization and claims review, fee-for-service schedules and payment, and operational aspects of the programs are established and controlled by, and medical services are provided by, independent, non-salaried solo-practitioners of medicine who join foundations as participating members. The foundation for medical care movement is a relatively recent phenomenon on the health service and health insurance scene; and, while being far from national in scope, it is growing steadily.

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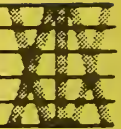
--- Health Maintenance Organizations (HMO) ---

Health maintenance organizations are beginning to emerge as potentially significant entities in the health-care delivery universe. The underlying concept of a health maintenance organization is that of a corporate vehicle comprised of a closed panel of multi-disciplinary salaried physicians undergirding a full complex of related health services and professionals brought together to promote the optimum health status of defined population groups. It provides enrolled members with unimpeded access to comprehensive preventive, diagnostic, and treatment services on an ambulatory, inpatient, emergency, or home care basis through capitation prepayment health insurance programs. A scattering of comprehensive prepayment health insurance plans of the HMO type are already operational. Many others are under study or are in advanced stages of development.

Single State agencies in a few States have undertaken to contract their medical review and inspection responsibilities to established foundations for medical care, or to closed-panel group medical practices the operational structures of which generally conform to the HMO concept. Operating experience with these arrangements is so far very limited. As experience is gained with the practical problems, their solutions, and the results of these programs, these guidelines will be revised and supplemented to make this information available. For those State agencies now considering such an arrangement the following caveats are in order:

- The corporate entity to which implementation of Section 250.23 may be contractually delegated must (a) structure multi-disciplinary teams, and (b) have the capability of carrying out on site in the facility all periodic medical review and inspection provisions of the Regulation.
- Despite such arrangement, the single State agency would still find it necessary to maintain the professional capacity and mechanisms for monitoring the performance and potentials of conflict of interest on parts of the contractors.

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The feasibility of special arrangements for reviews in selected areas with medical schools and teaching hospitals represent another possibility which some States may wish to explore. A future addition to these guidelines discussing the possibilities of such arrangements is planned.

Single State Agency Medical Review and Inspection Structures

So far many single State agencies have elected to organize and operate their own periodic medical review and inspection programs. Where that decision is made, the following are organization and operating requirements to be considered.

Organizational, procedural, and staffing considerations to be taken into account by the single State agency in planning its program of periodic medical review and inspections would include such matters as:

1. Space considerations:

- Office for a program director/coordinator
- Secretarial/clerical space
- Office(s) for physician team leader(s)
- Office(s) for nurse team member(s)
- Office(s) for social work team member(s)
- Conference Space for review team(s)

2. Program considerations:

- Developing basic operational format and policies
- Developing a manual of operating procedures
- Determining methods to be followed in such respects as
 - Orientation and staff training
 - Initial orientation and education methods to be utilized in acquainting provider facilities and the medical community with objectives, requirements, and mechanics of the program
 - Intra-agency record and filing systems
 - Inter-agency reporting and communications mechanics
 - Provider communications mechanics
 - Provider communications formats
- Projecting schedules for field visits
 - Estimates of on-site time requirements per provider facility
 - Estimates of travel time requirements

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(continued)

- Developing protocols for field visits
 - Pre-review analyses of patients to be reviewed and facilities to be inspected
 - Notifications to, and preparation to be made by, facilities scheduled for review
 - Formats to be followed on specific inspections.

3. Staffing considerations:

- Estimating staffing needs by job category
- Recruitment
 - Job specifications by category
 - Training, experience, and skills required by job category.

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Chapter VI

Suggested Format, Content, and Methodology for On-Site Periodic Medical Reviews and Inspections

Medical review strategies and tools discussed in this Chapter are intended to assist medical review teams to make periodic medical reviews and inspections efficient and effective, and economize professional manpower. Included are suggested procedures for pre-review processes, on-site review techniques, and post-review follow-ups; and related technical and functional aids, such as proforma check-lists, recording and reporting models, and examples of communications formats.

General Considerations

Patient Care vs Facility Assessments

Periodic medical reviews and inspections are almost exclusively patient centered. The main thrusts are:

- (1) evaluating the nature and seriousness of patients' clinical, physical, functional, emotional, and socially related problems;
- (2) determining whether these conditions, singly or in combination,
(a) are stationary, improving, deteriorating, or terminal, (b) require maximum, moderate, or minimal amounts of skilled professional and/or non-professional care on a short-run or continuing basis, and (c) allow the patients to function independently or call for physical assistance, emotional support, or personal supervision on a short-term or long-term basis;
- (3) ascertaining if care and services needed by such patients are being provided in kind and degree that give reasonable promise for improvement in or maintenance of optimal health status and independent functioning; and
- (4) judging the feasibility of utilizing alternative institutional or non-institutional care in meeting the current health and personal care needs of these patients.

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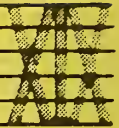
Thus assaying the quality and adequacy of physician services and nursing care is dominant in skilled nursing home medical reviews, and evaluating the appropriateness of active psychiatric care is predominant in mental hospital medical reviews. Yet attention should be given to operational and environmental factors in the provider facilities. In the course of carrying out basic patient-care evaluations, abundant opportunities exist for review team members to observe and react to a facility's overall functioning and tone. Shortcomings noted, general impressions gained, and conclusions reached by the review team should find their way into a narrative summary dealing with the facility in general. It is not the responsibility of the medical review team to apply facility standards or carry out survey functions normally the responsibility of the State survey agency. However, team members should be generally familiar with State and Federal requirements in areas directly affecting patient care and any deficiencies noted should be included in the summary report of the review.

Pre-Review Program Planning

Time and effort devoted initially by single State agencies to structuring sound basic frameworks for medical review programs; establishing uniform protocols for on-site reviews and team member roles; developing efficient techniques and time-saving methods for examining and assessing patient care and services; and preparing appropriate documentation and disseminating findings and recommendations, are an investment that can yield important dividends in expediting on-site reviews with a minimum expenditure of professional manhours and a maximum return in program effectiveness. However, once review formats and measurement criteria have been adopted, these should not become static. They must be tested, re-evaluated, and refined as necessary in order to ensure their continuing validity and consistent values to patients, provider facilities, and the public interest.

Effective achievement of the basic goals of medical review will be in direct proportion to the kinds and amount of forethought that go into developing the medical review and inspection program itself, and the degree to which medical review teams prepare in advance for individual on-site reviews and inspections.

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Basic Assumptions

Prototype organizational, administrative, and procedural matters covered in following parts of this Chapter, presuppose: (1) that all aspects of the medical review and inspection program are carried out by the single State agency, although they present an outline which can readily be adapted to a contractual program conducted by other agencies; and (2) that the composition of medical review teams and roles of its members as described in Chapter V prevail.

Internal Operational Policies and Practices

The diverse patterns of internal organization and extramural working relationships among title XIX agencies make it impractical to attempt to devise a set of operational formats applicable to all the States. The following are suggested as relevant components to be considered by the State agencies:

1. A program coordinator to organize, supervise, and control all internal non-professional operational routines and staff including:

- Developing and maintaining review team schedules and communications with provider facilities.
- Coordinating medical review follow-ups.
- Handling travel/hotel arrangements; and processing expense accounts.
- Coordinating secretarial and clerical staff.
- Ordering, maintaining, distributing, and controlling supplies.
- Handling mail and telephone.
- Establishing, maintaining, and controlling the records and filing systems.

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- Controlling the budget, and related financial transactions.
- Other appropriate managerial duties.

2. A records and filing system to ensure that information is readily available in the right place at the right time in a form that results in prompt decisions and timely actions. The system should include:

- Cross referencing, indexing, flagging, and other identifying methods that promote rapid location and retrieval, and accurate refiling of both vital and routine records and correspondence.
- A policy on records retention and periodic file "cleaning."
- Provision of routine and follow-up card and/or letter files.

3. Written procedures and related work-flow diagrams to show the various entities that are interrelated in carrying out the functions of periodic medical reviews and inspections and the sequence and scheduling of steps.

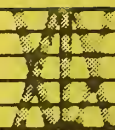
4. Encouragement of the routine use of standard pre-printed check-off or fill-in kinds of recording, evaluation, notification, communication, and reporting forms such as the prototypes presented in Chapter VII.

5. Distribution of time (days-of-the-week or weeks-of-the-month) of the medical review team and/or its individual members among:

- In-house review planning and follow-up.
- On-site reviews including travel time.
- Other duties.

6. Beyond routine formal communications and notifications to physicians and provider facilities, planned educational/public relations efforts to enhance understanding, acceptance, and support of the periodic medical review and inspection program, such as program presentations at medical society and nursing home regional meetings, and through medical review workshops.

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7. Programming for computer input and processing of statistical data, physiological profiles, and related information on patients, medical care patterns, provider facility factors, and the like deriving from periodic medical reviews.

8. Development and maintenance of detailed operating procedures and policy manual for reference of regular staff members and for orientation and training of new personnel.

External Program Relationships and Procedures

Advance Preparation for On-Site Review Visits

The highest proportion of the time and activity of medical review team members will be in the field. However, this does not diminish the value of office time spent on planning and preparation for on-site visits. Having at hand advance knowledge about patients and their problems can enhance material both the efficiency and the effectiveness of on-site medical reviews.

Information on the medical history, conditions, treatment regimen and other needs and characteristics of medical assistance patients in a skilled nursing home should be assembled and studied by the team before conducting the on-site review in the facility. A current list of patients for whom payments are being made to a particular facility may be obtained from the unit in the State responsible for accounting for such payments. Principal sources of prereview patient information are the files of the State agency relating to authorization of payment which should include the M.A. Patient Medical Evaluation Form (Exhibit I, Chapter VII or comparable document) completed by the admitting physician and the record of findings of previous medical reviews in the same facility.

Especially during the first years of the program information from reasonable recent medical evaluations may be inadequate or even non-existent. Where this is the case, the State agency may find it necessary, to properly prepare for initial reviews in each facility, to use the Pre-Review M.A. Patient Profile Form (Exhibit III) to provide a base line of medical and related information on each patient. This form would be filled out for each patient by professional nursing staff of the facility and returned to the State agency. Where this procedure is used care should be taken in the

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scheduling of subsequent on-site reviews to assure that receipt of the Pre-Review Patient Profile Forms is not tantamount to advance notification of the on-site review. Variations in the length of time between the request for prereview information and the actual review should be such that the date of on-site review does not become predictable.

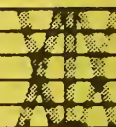
In addition to participating in the review of the information referred to above and in the planning of the on-site review, the social service member of the team should review the case files of the local assistance agency on the patients to be covered by the on-site review.

Fundamental Requirements: A recapitulation

By way of introduction to presentation of a suggested framework for on-site medical reviews, it seems appropriate to reiterate certain fundamental requirements and recommendations relative to medical review team composition and functions.

1. Periodic medical reviews must be conducted on site by review teams accompanied by and functioning under the supervision of a physician.
2. A registered professional nurse or nurses should be included as members of medical review teams.
3. The regulation calls for participation of social service personnel. This team member should be trained and knowledgeable in the social factors in illness.
4. On-site medical review teams composed as outlined above can be supplemented by the addition of any number of medical and para-medical professionals from a variety of relevant disciplines.
5. Intra-agency desk review by a physician of site-visit reports of nurses is not medical review within the meaning of Section 250.23. Hence, such a practice is unacceptable as compliance with the regulation.

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6. Use of on-site samplings of medical assistance patients, regardless of how selected, does not conform to the requirement of Section 250.23 that on-site medical review and evaluation must apply to each patient receiving care under the plan in a provider facility at the time of an on-site visit by a medical review team.
7. Reports to the single State agency should cover findings deriving from (a) examination and evaluation of the adequacy and currency of physician and nursing services as reflected in the medical record of each medical assistance patient being cared for in the provider facility; (b) professional observation and evaluation of the quality, sufficiency, and timeliness of medical, nursing, and personal care and services being received by each such patient; and (c), based upon specific findings of (a) and (b), the exercise of professional judgments as to the current appropriateness and quality of care of each such patient.
8. In lieu of (7) above, omnibus narrative reports on the provider facility as a whole and its patients in general are not acceptable.

Suggested Sequence of Medical Review Events

1. Review team prepares schedules for on-site reviews; and maintains advance schedules spanning 60-day periods.
2. Three weeks or more prior to the date of a scheduled on-site review visit, the review team assembles the medical evaluation and related information and prior review reports on each patient. If necessary, the review team sends pre-review patient profile forms (Exhibit III) along with a covering letter (Exhibit II-2, Chapter VII) to the provider facility. If these forms are not completed and returned in the time allotted, follow-up is made by telephone.
3. Review team analyzes pre-review patient information, develops a "feel" for the kinds of situations to be dealt with during review visit to the provider facility concerned; and, develops its overall strategy and work load distributions for the upcoming review. Pertinent notes are made on each patient and of any matters to be cleared up or to which special attention is to be paid during the forthcoming review.

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4. Immediately following the pre-review analysis by each member of the review team, and/or by the members collectively, a clerk transcribes the following data and notes to relevant columns and spaces provided on a pre-printed review team check-off form (Exhibit IV) for each patient:
 - Patient, facility, and physician identification data and related information.
 - "Alert" notes made for any patient-status, patient-care, or facility factors made by members of the review team during their pre-review analysis of patient information.
5. No more than 48 hours immediately preceding the exact date set for the on-site review, the provider facility concerned may be notified.
6. Upon arrival at the provider facility, the review team meets with the administrator and/or chief nurse for an introductory conference during which the purposes of periodic medical review are explained and the general format to be followed by the review team and its individual members during the course of the visit is outlined.
7. Work of members of the review team than proceeds according to plan.
8. At the conclusion of the on-site review, and following a group round-up conference of members of the review team, a meeting with the administrator and chief nurse of the provider facility is held for the purpose of informally summarizing general findings and possible recommendations, seeking additional information about specific patients, practices, or services that could bear on conclusions and recommendations, and making suggestions that could benefit the facility and the patients.
9. If, during the course of patient evaluations, conditions or practices are found that are considered to be seriously detrimental to patients, or, where treatment practices or medication regimens currently being followed for given patients are considered to place such patients in serious jeopardy, the review team physician leader will take appropriate steps in the most expeditious manner possible to bring

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these conditions to the immediate attention of the attending physician or official agency concerned.

Review Team Members' Roles In On-Site Reviews

The variations in numbers of medical assistance patients to be covered in a given on-site review, the mix in organizational structures, policies and practices among provider facilities, and the variables in sophistication of physician practice patterns in the medical communities supporting provider facilities are such that no one set of medical review routines could precisely fit all of them.

Utilizing the review team check-off form (Exhibit IV, Chapter VII) as a guide, the following roles and work distributions and interplay among review team members probably would be found to be feasible in most instances:

1. Work entitled in Section A "Evaluation of Physician Care and Services" seems to fall properly within the purview of the physician team leader. Since this is focused almost exclusively on review and analysis of data contained in patients' medical records, and because the same records must be reviewed for adequacy of nursing care factors, a decision must be made as to whether medical records will be reviewed separately or jointly by the physician member and nurse member of the team.
2. By reviewing jointly, determinations as to precisely which patients should be observed and evaluated by the physician member can probably be made more realistically. In that circumstance, it might be desirable to have more than one nurse member of the team so that individual patient observations and evaluations could be going on concurrently with the joint medical records review. By so doing, most of the work entailed in Section B, Exhibit IV, "Evaluation of Nursing Care and Services," could be proceeding without intrusion on the medical records review process.
3. Comparative patient-care assessments as these are detailed in Sections C. and D. of Exhibit IV call for observation and probing by a nurse in all instances and nurse/physician participation in some cases. Again, the key role of nurses in periodic medical review and inspection processes shows up.

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4. Assessments of treatments and nursing care, as these are identified in Sections E. and F. of Exhibit IV, would be accomplished most meaningfully when carried out jointly by the physician and a nurse member of the review team.
5. Work entailed in Section G, "Social Service Assessment of This Patient" of Exhibit IV, obviously is the singular role of the social work member of the review team.
6. Collective judgments of all members of the review team are involved in the decision making processes entailed in the implementing "Assessment of Progress of This Patient" and formulating "Reviewers' Recommendations" as these are outlined in Section H. of Exhibit IV.
7. Again, collective judgments of all team members are required to reach conclusions with respect to factors enumerated under the heading "General Appraisal of Provider Facility and Services" at the end of Exhibit IV.

Some General Observations on Review Procedure

1. Any arbitrary selection of a fixed percentage of a provider facility's medical assistance patient population to be observed individually by the physician member of the review team would be inappropriate. This could possibly result in his seeing many patients whose conditions don't require his professional judgments and overlooking those who do. A much more acceptable arrangement would be (a) for a nurse member of the review team to identify specific patients to be observed by the physician member; (b) for the physician member to observe all patients in company with a nurse reviewer for evaluation of particular factors relative to the patient's medical status and care, e.g., those in Section E. and F. of Exhibit IV of Chapter VI, or (c) for the physicians to identify from review of the medical records as well as the recommendations of the nurse member those cases where physician observation is indicated.
2. Interviews with patients probably can be done best in the absence of facility staff members, if candor on the part of patients is to be expected.

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3. If any priority categorization of patients for review is to be made, perhaps it should be limited to: (1) newly admitted patients, or those admitted within 30-60 days preceding the review; and (2) those cases which the review team has identified as being "questionable" for some reason based upon analysis of pre-review patient profiles.
4. There may be certain psychological advantages, and possibly some legal security, in a policy that calls for all patients to be observed and evaluated by two review team members concurrently.
5. If circumstances with respect to a given patient indicate a need for the physician team member to physically examine a patient, inherent legal risks make it prudent for the physician to: (a) have a nurse present; and (b) get at least oral, and preferably a signed, permission from the patient for such examination in the presence of the nurse.
6. The nature and number of factors that must be taken into account in making objective determinations of the appropriateness and necessity for patients' current placement or the suitability and reasonableness of alternative placement, call for the pooling of judgments that are based upon professional knowledge and insights possessed only by experienced physicians, nurses and professional social workers. This means that a mathematically oriented point-rating system could not be considered as being an equally acceptable vehicle for that purpose.

A point-rating system may have some merit in rate setting or in facility classification processes where incentive points for excelling standard performance norms can make the system work in the right direction. However, when the earning of more points is based upon degrees of seriousness of disabilities and/or degrees of intensity, frequency, or complexity of needed care, point-rating systems can actually be counter-productive in terms of achieving health and functional goals for patients through improvements in treatment and related services.

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On-Site Periodic Medical Reviews and Inspection (continued)Periodic Medical Review and Intermediate Care Facilities

Boundaries for application of the provisions and requirements of Section 250.23 are clearly drawn by the statute. Accordingly substantive content of this guideline document has been similarly focused. However, Public Law 92-223, which transferred the ICF program to title XIX, included requirements for an Independent Professional Review program in ICFs. The statutory language for Independent Professional Review is almost identical to the language for Periodic Medical Review. Therefore, there is no foreseeable reason why much of the same mechanism and staff put together for implementation of Section 250.23 cannot be carried over to accomplish a similar purpose in ICFs.

The ICF program under title XIX is designed to provide "health-related care and services" to individuals whose "mental or physical condition" necessitates institutional care beyond room and board but less than skilled nursing home care. Modification of organizational and procedural patterns devised to apply to patient care circumstances in skilled nursing homes and mental hospitals will be necessary to place emphasis on the evaluation of non-medical aspects of patient care and health maintenance and to make the team composition more appropriate to the special needs of ICF residents.

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Chapter VII

Exhibits

(Examples only)

THIS CHAPTER CONTAINS THE FOLLOWING EXHIBITS

- EXHIBIT I : ATTENDING PHYSICIAN: M.A. PATIENT MEDICAL EVALUATION FORM
- EXHIBIT II : PROTOTYPE LETTERS, NOTIFICATIONS, PATIENT EVALUATION, AND REPORTING FORMS
- EXHIBIT III: PRE-REVIEW M.A. PATIENT PROFILE FORM
- EXHIBIT IV : REVIEW TEAM CHECK-OFF FORM

The examples of forms and letters are intended:

1. To relate directly to the conceptual model of the organizational structure and procedural routines which were developed and discussed in Chapter VI for a hypothetical periodic medical review and inspection program.
2. To serve as suggested thought-starter concepts and formats for adoption or adaptation by existing or developing periodic medical review and inspection programs.

ATTENDING PHYSICIAN M. A. PATIENT MEDICAL EVALUATION FORM

EXHIBIT 1
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PATIENT'S LAST NAME FIRST NAME INITIAL BIRTH DATE SEX MEDICAID NO. MEDICARE NO.

PATIENT'S PERMANENT ADDRESS
(Street number, City, County, Zip Code)

PATIENT ADMITTED FROM: (Hospital, Home, Other Facility)

PATIENT APPLYING FOR ADMISSION TO:
(Give name & address of facility)

PHYSICIAN'S NAME & ADDRESS

CURRENT DIAGNOSES

Primary <u> </u>	Month's Duration <u> </u>	Secondary <u> </u>	Month's Duration <u> </u>
Secondary <u> </u>	Month's Duration <u> </u>	Most recent surgery <u> </u>	Date: <u> </u> / <u> </u> / <u> </u>

LABORATORY FINDINGS

Hemoglobin <u> </u>	Date <u> </u> / <u> </u> / <u> </u>
Hematocrit <u> </u>	Date <u> </u> / <u> </u> / <u> </u>
WBC <u> </u>	Date <u> </u> / <u> </u> / <u> </u>
Bun <u> </u>	Date <u> </u> / <u> </u> / <u> </u>
Blood Sugar <u> </u>	Date <u> </u> / <u> </u> / <u> </u>
Urine Sugar <u> </u>	Date <u> </u> / <u> </u> / <u> </u>

Albumin <u> </u>	Date <u> </u> / <u> </u> / <u> </u>
Sp. Gr. <u> </u>	Date <u> </u> / <u> </u> / <u> </u>
ECG <u> </u>	Date <u> </u> / <u> </u> / <u> </u>
Chest Xray <u> </u>	Date <u> </u> / <u> </u> / <u> </u>
Pul. Funct'n <u> </u>	Date <u> </u> / <u> </u> / <u> </u>
Other <u> </u>	Date <u> </u> / <u> </u> / <u> </u>

MEDICAL CONDITIONS

WHICH OF THE FOLLOWING APPLY TO THIS PATIENT?

(PLEASE GRADE AS: (0) = No (1) = Yes (2) = Severe)

() Pain	() Incontinence of Bowel	() Deafness	() Noisy
() Shortness of Breath	() Incontinence of Bladder	() Speech Impairment	() Wanders
() Contractures	() Superficial Bed Sores	() Lethargy	() Combative
() Difficulty Swallowing	() Extensive Bed Sores	() Coma	() Withdrawn
() Tube Fed	() Other Ulcers or Wounds	() Mental Confusion	() Depressed
() Bladder Catheter	() Blindness	() Hallucinates	() Suicidal

DOES THIS PATIENT HAVE ANY OF THE FOLLOWING?

(PLEASE CHECK AND EXPLAIN UNDER COMMENTS)

() HEART DISEASE (Identify below)	() Cerebral Insufficiency	() Osteoporosis
() Arteriosclerotic	() Cerebral Vascular Accident	() Neurological Disorders
() Rheumatic	() Diabetes Mellitus	() Paralysis
() Congenital	() Pulmonary Disease	() Liver Disease
() Congestive Failure	() Emphysema	() Anemia (type)
() Coronary/Pulmonary	() Asthma	() Blood Disorders (type)
() Other	() Hayfever (give season)	() Cancer (location)
	() Allergies (list below)	() Fracture (location)
() Hypertension	() Drug Reaction (list below)	() Kidney Disease
() Peripheral Vascular Disease	() Rheumatoid Arthritis	() G-I Disorders (list)
	() Osteoarthritis	() Any communicable disease
COMMENTS:		

PHYSICAL EXAMINATION

DATE / /

CHECK IF ABNORMAL and DESCRIBE IF SIGNIFICANT

1. EYES (Discharge, Strabismus, Pterygium, Ptosis, Fundi, Cataract, etc.)	11. VEINS (Varicose, Location, Severity)
2. EARS (Evidence of Deafness, Middle Ear or Mastoid Disease. Drums: Absent Perforated, Dull, Retracted. Discharge)	12. ABDOMEN (Scars, Masses, Palpable Liver or Spleen, Tenderness)
3. NOSE (Obstruction. Evidence of Chronic Sinus Infection, Polypi)	13. HERNIA (Site, Type, Severity)
4. THROAT (Tonsils: Enlarged, Removed)	14. GENITALIA-MALE (Discharge, Variocele, Hydrocele, Prostate)
5. MOUTH (Missing Teeth, Pyorrhea, Caries, Abnormal Tongue or Palate)	15. GYNECOLOGICAL (Describe Significant Abnormal Condition, Severity & Extent)
6. NECK (Thyroid Enlargement, Nodules, Nodules, Masses)	16. ANO-RECTAL (Severity and Extent of Hemorrhoids, Prolapse, Fissures, Fistula, etc.)
7. BREASTS (Abnormal Discharge, Nodules, Tenderness)	17. NERVOUS SYSTEM (Gait, Reflexes Sensation, Paralysis, Speech, Etc.
8. LUNGS (Conformation, Respiratory Movement. Breath Sounds, Rales, Dullness)	18. PSYCHIATRIC (Mood, Abnormal Behavior, etc.)
9. HEART (Enlargement, Thrills, Murmurs, Rhythm, Dyspnoea. Cyanosis. Edema)	19. SKIN (Lesions, Scars, Abnormalities - Extent and Severity)
10. ARTERIES (Peripheral Pulsations)	20. ORTHOPEDIC (Congenital or Acquired Impairments, Feet, Back, Amputations, etc.)

HEIGHT WEIGHT BLOOD PRESSURE / PULSE RHYTHM

PATIENT'S STATUS: () Stable () Improving () Deteriorating () Terminal

THERAPY

	YES	NO		YES	NO		YES	NO
I.V. & Subcut. Fluids	()	()	Special Dressings	()	()	Inhalation Therapy	()	()
Physical Therapy	()	()	Irrigations	()	()	Activity Program	()	()
Speech & Hearing Therapy	()	()	Special Skin Care	()	()	Podiatry Care	()	()
Occupational Therapy	()	()	OTHER					

ORDERED LABORATORY TESTS:

Procedure	Frequency
Procedure	Frequency
Procedure	Frequency

DIETARY REGIMEN:

PRESCRIBED ORAL MEDICATIONS - ONLY AS SPECIFICALLY DIRECTED

Drug	Dosage	Frequency

PRESCRIBED ORAL MEDICATIONS - PER NURSE'S JUDGMENT

Drug	Dosage	Frequency

PRESCRIBED INJECTABLES - ONLY AS SPECIFICALLY DIRECTED

Drug	Defined Limits	Frequency

PRESCRIBED INJECTABLES - PER NURSE'S JUDGMENT

Drug	Defined Limits	Frequency

(Therapy - Continued)

PRESCRIBED SPECIAL CARE PROCEDURES (e.g., Respiratory Therapy; Bed Positioning & Turning; Irrigations; Dressings; Soaks, etc.)

Frequency and Instructions

REHABILITATION/RESTORATIVE PROCEDURES: (e.g., Gait Training; Range of Motion Exercises; Electrotherapy; Thermotherapy; Hydrotherapy, etc.)

Procedure	Instructions	By Whom	Restorative Potential

GENERAL

CARE IN THIS FACILITY SHOULD RESULT IN: () Improved health status () Improved mental status
() Improved physical functioning () Self-care capability () Home care potential
() Possible placement in facility providing less active skilled care.

PROBABLE TIME CURRENT LEVEL OF CARE REQUIRED: () Permanent () Temporary, as measured in _____ months.

ALTERNATIVE CARE CONSIDERED: The following alternative arrangements for care of this patient at this time were considered and rejected as not being sufficient or appropriate for meeting his present needs:

Intermediate Care _____ Residential Care _____
Foster Family Care _____ Home Health Care _____ Own Family Care _____

PLANS FOR ALTERNATIVE CARE FOLLOWING DISCHARGE FROM THIS FACILITY: () No discharge anticipated () To home
() Continued care in (specify Intermediate, Residential, etc.) _____

PHYSICIAN RECOMMENDATION: I certify that this patient's medical condition and related needs are essentially as indicated above; and that care in this facility is necessary.

DATE / / PHYSICIAN'S SIGNATURE _____ (M.D.) (D.O.)
Telephone No. _____

EXHIBIT II

PROTOTYPE LETTERS, NOTIFICATIONS, PATIENT EVALUATION, AND REPORTING FORMS

Seven prototype letters, notification, evaluation, and reporting forms referred to and discussed throughout text of Chapter VI are found in this Exhibit. They are:

- Letter to patients when alternative care is to be recommended. (Exhibit II-1).
- Letter to attending physicians when alternative care is recommended. (Exhibit II-2).
- Letter to provider facilities requesting completion of Pre-Review Patient Profile Forms. (Exhibit II-3).
- Report letter to provider facilities incorporating findings and recommendations of the Medical Review Team. (Exhibit II-4)
- Letter to official agencies concerned recommending alternative placement of a given patient, and requesting initiation of appropriate action. (Exhibit II-5).

LETTERHEAD OF THE TITLE XIX STATE AGENCY

Proforma Text of Letter to Patients When Findings
of a Medical Review Indicate the Appropriateness
of Transfer to an Alternate Level or Mode of Care;
and When Such a Recommendation is to be Made to
the Local Assistance Agency and/or Office Concerned.

Pt's Name _____
M.A. No. _____
Facility _____

Dear _____:

Our medical review team visited you recently to evaluate your health and related needs, and the level and kinds of care you are receiving currently. Such visits are required by Federal and State Medicaid regulations for all medical assistance patients receiving care in approved skilled nursing homes, (65 years of age or older, care in an approved hospital for mental diseases.)

Members of our medical review team who visited you concluded that your health and related needs can best be met by placement in or transfer to _____ (level & type of care) _____. We plan to recommended this to _____ (public assistance office) _____.

The _____ (facility name) _____ and your personal physician have been notified of this finding and recommendation. Your physician is being given an opportunity to submit additional information beyond that found in your medical record if he feels it might influence the decision of our Medical Review Team.

A representative from _____ (public assistance office) _____ will visit you soon to answer any questions you may have about the recommendation of our medical review team, and to assist with your placement in a facility or other kind of care better suited to your current health and related needs.

Sincerely,

(formal title of Single State Agency)

cc: Local and/or State Public
Assistance Agency
Attending physician
Provider facility

Letter to Patients Re
Alternative Placement

LETTERHEAD OF THE TITLE XIX STATE AGENCY

Proforma Text Of Letter To Personal Physicians
Of Patients Adjudged By Medical Review Teams
As Not Requiring The Skilled Level Of Care
Currently Being Provided.

Pt's Name _____
M.A. No. _____
Facility _____

Dear Dr. _____:

The patient identified above who is under your care has been evaluated by our medical review team to assess the need for continuation of the current level and kind of care being received, and hence, the necessity of remaining under care in the provider facility named.

Our observations and findings indicate that this patient's condition has reached a point where the full range of services and intensity of care being provided currently are no longer necessary; and that the health and related needs of the patient can be met adequately by alternative placement in or transfer to __ (level & type of care) __. We plan to make this recommendation to __ (public assistance office) __.

It is recognized that there may be extenuating factors known to you which might justify continuation of care for this patient in the present setting. Therefore, if you have any question about our determination, we would welcome further information from you regarding any unique medical needs of this patient beyond those reflected in his medical record. This should reach us within 15 days of the date of this letter.

If you concur with the recommendation and planned action of our Medical Review Team, please sign and return the attached duplicate of this letter. Unless we hear from you within 15 days, we shall proceed as planned.

Sincerely,

I concur with findings and
proposed action concerning
the above patient.

Signed _____ M.D.
Date _____.

(formal title of Single State Agency)

Letter to attending physicians
of review findings and recom-
mendations.

EXHIBIT II-3
PROFORMA
LETTER #3

LETTERHEAD OF THE TITLE XIX STATE AGENCY

Proforma Text of Letter to Provider Facilities
Requesting Completion of Detailed Patient
Profiles for Each Medical Assistance Patient
Under Care in the Facility.

Name and Address of
Provider Facility:

Title XIX of the Social Security Act requires that State agencies administering Medicaid programs conduct periodic medical reviews of all medical assistance patients receiving care in skilled nursing homes (or mental hospitals) approved as provider facilities by title XIX State plans.

Before scheduling a visit of our medical review team to your facility, we wish to have you provide us with a status profile for each of your medical assistance patients. Our records indicate that there are _____ such patients in your facility, and accordingly, we are enclosing slightly more than that number of multi-copy forms to be filled out by typewriter, but if not, use a good quality ball-point pen, press firmly, and print the information needed cleanly and legibly. It is essential that these reports be returned not later than ten days following the date of this letter.

Based upon pre-visit desk reviews of your patients' current profiles, our medical review team can program in advance the most efficient and effective ways of carrying out its on-site evaluations. Such an overview of your medical assistance patients will save your staff and our review team members a great deal of time, as well as minimizing minor disruptions to your normal operating routines.

Your cooperation in completing these patient profile forms will provide us with uniform basic information on your patients which will be kept current through the medical review program. We do not expect that it will be necessary to ask you to repeat this process in the future.

Sincerely,

(formal title of single State agency)

Letter to provider facilities requesting
profile reports on M.A. patients.

LETTERHEAD OF THE TITLE XIX STATE AGENCY

Proforma Text Of Letter To Provider Facilities
Summarizing Findings, Decisions, And Recom-
mendations Arising From Medical Review And
Inspection Of The Facilities Concerned.

Name and address
of facility:

A medical review of medical assistance patients and inspection of your facility was conducted by our medical review team on __ (date) ____.

The medical review team's observations, findings, and recommendations are contained in this report. These findings and recommendations are concerned specifically and exclusively with the proper placement, appropriateness, and range and quality of care being provided in your facility for medical assistance patients eligible for care under the State's Medicaid program. They are not intended to imply that the facility is or is not in compliance with licensure codes, or with other standards and requirements of any State or Federal health program.

As required by Federal regulations, copies of this evaluation and recommendations are being forwarded to __ (names of local or State official agencies) ____.

Deficiencies found by the medical review team on which remedial or corrective action is indicated and recommended are noted under relevant factorial headings appearing below. Some of these were discussed with you at the conclusion of the inspection. It is requested that you inform us within thirty days of remedial or corrective actions taken or changes in procedures instituted with respect to any and all deficiencies cited. If you have questions on the substance of this report, or if we can be of assistance in regard to effecting indicated improvements, please let us know.

M.A. patients reviewed _____

M.A. patients recommended for alternative placement _____

To Intermediate Care _____ To Residential Care _____

To Home Care _____ To Other Mode of Care _____

Letter to Provider Facilities Covering
Review Findings & Recommendations

(more)

FINDINGS AND RECOMMENDATIONS

	<u>Accept- able</u>	<u>Unaccept- able</u>	<u>Comments and Recommendations</u>
1. <u>Medical Records:</u>			
(a) Admiss'n history & physical	_____	_____	_____ _____
(b) Phys'n justification for admission	_____	_____	_____ _____
(c) Phys'n written prognosis	_____	_____	_____ _____
(d) Phys'n plan of care	_____	_____	_____ _____
(e) Phys'n treatment orders (30-day)	_____	_____	_____ _____
(f) Phys'n recert'n of medications(30-day)	_____	_____	_____ _____
(g) Phys'n visits (30-day)	_____	_____	_____ _____
(h) Phys'n progress notes (30-day)	_____	_____	_____ _____
(i) Reports of treatment results	_____	_____	_____ _____
(j) Rehab. plan of care(if applicable)	_____	_____	_____ _____
(k) Spec. treatment orders	_____	_____	_____ _____
(l) Spec. treatment results	_____	_____	_____ _____
(m) Spec. diagnostic tests	_____	_____	_____ _____
(n) Dietary orders & restrictions	_____	_____	_____ _____
(o) Nursing plan of care	_____	_____	_____ _____

(more)

	Accept- able	Unaccept- able	Comments and Recommendations
(p) Nurses' progress notes	_____	_____	_____ _____
(q) Psychosocial needs & care	_____	_____	_____ _____
(r) Planned activities program	_____	_____	_____ _____
(s) Family relation- ships & support	_____	_____	_____ _____
(t) Social plann- ing & support	_____	_____	_____ _____
(u) Discharge plann- ing & prospects	_____	_____	_____ _____
(v) General remarks	_____	_____	_____ _____ _____

2. Patients' Status:

(a) Cleanliness bed & body	_____	_____	_____ _____
(b) Signs of decubiti	_____	_____	_____ _____
(c) Signs of malnutrition	_____	_____	_____ _____
(d) Signs of dehydration	_____	_____	_____ _____
(e) Evidence of optimum physical, mental & social functioning	_____	_____	_____ _____ _____
(f) Evidence that care of wounds, colostomies, catheters, tracheosto- mies, etc. is skilled	_____	_____	_____ _____ _____

(more)

	Accept- able	83 Unaccept- able	Comments and Recommendations
(g) Evidence of training & assistance for patients with phys. disabilities & limitations	_____	_____	_____ _____ _____ _____
(h) Evidence of assistance & training for toilet functions	_____	_____	_____ _____ _____
(i) Evidence of exercises, turning, positioning, etc. to maintain circulation & prevent contractures	_____	_____	_____ _____ _____ _____ _____
(j) Evidence of safety precautions in use of wheelchairs, bed/chair transfers, etc.	_____	_____	_____ _____ _____ _____
(k) Evidence of restorative nursing care, & training in self care	_____	_____	_____ _____ _____ _____
(l) Accessibility to special services not provided by the facility	_____	_____	_____ _____ _____ _____
(m) Evidence that care is considerate, and adequate to meet health needs and promote patients' general well-being & social welfare	_____	_____	_____ _____ _____ _____ _____ _____
(n) Evidence that all services ordered are carried out at the right time in the right way, and are properly recorded	_____	_____	_____ _____ _____ _____ _____
(o) Evidence of patients' satisfaction with care received	_____	_____	_____ _____ _____ _____
(p) Evidence of on-going pt. evaluations as to feasibility of alternate level of care	_____	_____	_____ _____ _____ _____

(more)

	<u>Accept- able</u>	<u>Unaccept- able</u>	<u>Comments and Recommendations</u>
(q) Facility cooperation in all aspects of medical review	_____	_____	_____ _____

(r) General remarks: _____

4. General observations on facility operations, environment, supervision, staffing, etc. and capabilities and resources for meeting 'full range of patients' needs:

A. Re.Procedures & Practices Affecting Patients' Health & Welfare:

[illegible]

(more)

B. Re. Care, Treatment, or Placement of Individual Patients:

[illegible]

A formal response as to remedial or corrective actions to be taken or changes in procedures instituted with respect to the above recommendations is required within thirty days of the date of this report.

Signed,

cc. - Local and/or State Public Assistance Agency
- Utilization Review Committee
- Other appropriate local or State official agencies.

(formal title of Single State Agency)

LETTERHEAD OF THE TITLE XIX STATE AGENCY

Proforma Text Of Notification Letter To Local
And/Or State Public Assistance Agency Or
Office As Appropriate, Stating Findings And
Recommendation Of The Medical Review Team;
And Requesting Alternate Placement Of The
Patient Concerned.

Pt's Name _____
M.A. No. _____
Facility _____

Name and address of
appropriate public
assistance agency:

RECOMMENDATION FOR ALTERNATIVE PLACEMENT

Pursuant to a medical/social evaluation by our medical review team of
the above patient who is currently receiving (skilled nursing/psychiatric care)
in the named provider facility; it has been determined that this individual no
longer requires the full range of services and active care provided by that
provider facility.

Alternate placement in or transfer to _____ (type of care) _____
appears to be appropriate and sufficient for meeting the health and related needs
of this patient; and our medical review team so recommends.

Accordingly, we request that you take early and necessary action in arranging
for the alternate placement of this patient in the type of care recommended.

Sincerely,

(formal name of Single State Agency)

cc. Patient
Attending Physician
Provider Facility

Letter to Public Assistance Agency
When Alternative Care Recommended.

PRE-REVIEW

M.A. PATIENT PROFILE

<u>PT'S LAST NAME</u>	<u>INITIAL</u>	<u>FIRST NAME</u>	<u>SEX</u>	<u>NAME OF FACILITY</u>
<u>PT'S HOME ADDRESS</u>			<u>AGE</u>	<u>ADDRESS OF FACILITY</u>
<u>ADMITTED FROM</u>	<u>HOME</u>	<u>HOSP.</u>	<u>OTHER FAC.</u>	<u>DATE</u>
<u>MEDICAID NO.</u>		<u>MEDICARE NO.</u>		<u>PHYSICIAN'S NAME</u>
<u>IF NOT MEDICARE, WHY NOT:</u>				<u>TELEPHONE NO.</u>
<u>CONDITION:</u>	<u>Improving ()</u>	<u>Static ()</u>	<u>Declining ()</u>	<u>PHYSICIAN'S ADDRESS</u>
				<u>PRIMARY DIAGNOSIS</u>
				<u>LAST VISIT</u>
				<u>SECONDARY DIAGNOSES</u>

PHYSICAL AND MENTAL FUNCTIONAL STATUS

BED STATUS: Bedfast () In most time () In part time () Out except rest () Needs bedrails/restraints ()

AMBULATION STATUS: Cannot () No weight bearing () Independently () With help () With walker ()
With cane () With crutch () Ascend/descend () Wheelchair () Chair-bound ()

TRANSFER STATUS: Help to & from bed () Help in and out of wheelchair & seating () Help to standing position ()
Help to tub/shower () Needs portalift ()

ACTIVITY STATUS: Leaves fac. to visit () Socializes () Participates () Enjoys TV/Radio () Reads ()
Sews () Has hobby () Lethargic () Unmotivated ()

MENTAL STATUS:

Alert () Disoriented () Agitated () Forgetful () Withdrawn () Drooler ()
 Apathetic () Hallucinates () Noisy () Hostile () Wanders () Depressed () Spitter ()
 Suicidal () Needs Superv'n for pers. affairs & safety () Causes mod. () Severe () mgem't prob's.

GROOMING STATUS:

Bathes unassisted () Bathes with help () Bathes with total help () Dresses unassisted ()
 Dresses with help () Dresses with total help () Shaves unassisted () Shaves with help ()
 Shaves with total help () Hair care unassisted () Hair care with help ()
 Hair care with total help ()

DIET STATUS:

Regular () Special foods () N.G. Tube feeding () Pureed () Quantitative diabetic ()
 High/Low special diets ()

FEEDING STATUS:

Uses dining room () Bed Tray () Tray in room () Feeds self () Needs assistance ()
 Must be fed () Difficulty swallowing () Clean-up problem after feeding ()

PERSONAL TOILET STATUS:

Without help () Help on & off toilet/commode () Must be reminded ()
 Needs bedpan/urinal ()

SENSORY/COMMUNICATION STATUS:

Loss of sensation () Impaired speech () Impaired sight ()
 Impaired hearing () Blind () Aphasic () Deaf () Foreign tongue ()

ORAL HYGIENE STATUS:

Self () With some help () With total help () Edentulous () Dentures ()

NAIL AND FOOT CARE STATUS:

Self () Needs assistance () Must be done totally () Care by podiatrist req'd ()

PROSTHESIS:

Body cast/brace () Arm cast/brace () Leg cast/brace () Artificial limb () Cervical collar ()
 Applied by self () Applied with help ()

SELF-CARE STATUS:

Unable to participate () Able to participate in the following ways:-----

SIGNIFICANT DISABLING CONDITIONS AND RELATED PROBLEMS

PAIN: Intractable () Constant () Intermittent () URINARY INCONTINENCE: Partial () Total ()

AMPUTATION: Upper extremity () Lower extremity () FECAL INCONTINENCE: Partial () Total ()

BREATHING DIFFICULTY: Asthmatic () Other () ILEOSTOMY/COLOSTOMY ()

BED SORES: Superficial () Extensive () LESIONS: Unhealed wounds () Fistula () Other ()

CONTRACTURES: Organic () Ischemic () TRACHEOSTOMY ()

COMATOSE: () INDWELLING TUBES AND CATHETERS: ()

CONVULSIONS OR SEIZURES: Frequent () Occasional () OTHER: () Describe:

SPECIAL TREATMENTS AND NURSING CARE

FREQUENCY CODE: 1 = LESS THAN ONCE DAILY 2 = ONCE DAILY 3 = MORE THAN ONCE DAILY 4 = PRN

<u>THERAPY</u>	<u>FREQUENCY</u>				<u>THERAPY</u>	<u>FREQUENCY</u>			
MAINTENANCE DRUGS	1	2	3	4	ENEMAS	1	2	3	4
COMPLEX DRUGS	1	2	3	4	PACKS (COLD/HOT)	1	2	3	4
ILEOSTOMY/COLOSTOMY CARE	1	2	3	4	SITZ BATH or PERINEAL CARE	1	2	3	4
CATHETERIZATION	1	2	3	4	SOAKS	1	2	3	4
CATHETER/TUBE CHANGE or IRRIGATION	1	2	3	4	VITAL SIGNS	1	2	3	4

(Special Treatments and Nursing Care - cont'd)

<u>THERAPY</u>	<u>FREQUENCY</u>				<u>THERAPY</u>	<u>FREQUENCY</u>			
LESION IRRIGATION	1	2	3	4	SPEC. FRACTURE or PROSTHETIC CARE	1	2	3	4
STERILE DRESSINGS	1	2	3	4	INTAKE-OUTPUT MEASURES	1	2	3	4
NON-STERILE DRESSING CHANGE	1	2	3	4	SPECIAL SKIN CARE	1	2	3	4
FLUID THERAPY (IV or SQ)	1	2	3	4	RANGE OF MOTION or GAIT EXERCISES	1	2	3	4
SUCTIONING	1	2	3	4	FEEDING OTHER THAN BY MOUTH	1	2	3	4
INHALATION THERAPY or I.P.P.B.	1	2	3	4	SPECIAL BED CARE (turning, position- ing, etc.)	1	2	3	4
TRACHEOSTOMY CARE	1	2	3	4	IN-FACILITY LABORATORY TESTS	1	2	3	4
BLADDER AND/OR BOWEL TRAINING	1	2	3	4	OTHER SPECIAL CARE(-----)	1	2	3	4

OTHER THERAPIES BEING RECEIVED
(On Physician's Orders)

PHYSICAL THERAPY () OCCUPATIONAL THERAPY () PODIATRY CARE () PSYCHOTHERAPY ()
SPEECH/HEARING THERAPY () DENTAL CARE ()

TREATMENT GOALS FOR THIS PATIENT

IMP. HEALTH STATUS () IMP. PHYSICAL FUNCTIONING () IMP. MENTAL FUNCTIONING ()
SELF-CARE POTENTIAL () ALTERNATIVE PLACEMENT ()

ALTERNATIVE CARE BEING CONSIDERED FOR THIS PATIENT

Basic Intermediate ()	Custodial Intermediate ()	Foster Family Care ()	Own Family Care ()
Home Health Care ()	None ()		

SOCIAL NEEDS OF THIS PATIENT

1. Does this patient have any major unmet social or related needs that may be affecting his health and welfare adversely? If so, please explain; and, state what steps have been taken or should be taken to resolve these problems?
-
-
-
-
-
-
2. Does your facility have full-time () part-time () or consultative () social work services available for its patients? If not, please describe how these services are provided when needed by your medical assistance patients.

DATE: / /

Name of Administrator or Chief Nurse
Making This Report: _____
(Print)

DATE OF SITE
VISIT / /

REVIEW TEAM CHECK-OFF FORM

<u>NAME OF FACILITY</u>		<u>ADDRESS OF FACILITY</u>	
<u>BED CAPACITY</u>	<u>PT. CENSUS TODAY</u>	<u>M.A. PT. CENSUS TODAY</u>	<u>ADMINISTRATOR</u>
			<u>CHIEF NURSE</u>
<u>PT'S LAST NAME</u>	<u>INITIAL</u>	<u>FIRST NAME</u>	<u>HOME ADDRESS</u>
<u>PT'S AGE</u>	<u>SEX</u>	<u>DATE ADMITTED</u>	<u>ADMITTED FROM:</u>
			<u>HOME</u> <u>HOSPITAL</u> <u>OTHER LONG TERM FACILITY</u>
<u>MEDICAID NO.</u>	<u>MEDICARE NO.</u>	<u>IF NOT MEDICARE ELIGIBLE, WHY NOT</u>	
<u>DIAGNOSIS (Primary & Secondary)</u>		<u>IMPROVING</u>	<u>STATIC</u> <u>DECLINING</u> <u>TERMINAL</u>
<u>PHYSICIAN'S NAME</u>	<u>PHYSICIAN'S ADDRESS</u>	<u>TELEPHONE NO.</u>	
<u>DATE OF PHYSICIAN'S LAST VISIT</u>	<u>DATE OF PHYSICIAN'S SECOND LAST VISIT</u>	<u>DATE OF LAST PHYS. EXAM. OF PATIENT</u>	

A. EVALUATION OF PHYSICIAN CARE AND SERVICES

AS REFLECTED BY SIGNED AND DATED ENTRIES IN THE MEDICAL RECORD OF THIS PATIENT

FACTOR	Yes No		REVIEWER COMMENTS
	Yes	No	
1. Rationalization/Justification for Adm. Stated			
2. Hist. & Phys. Exam. Recorded & Current			
3. Med. Findings & Diagn. Complete & Current			
4. Phys. & Mental Capacity & Functioning Stated			
5. Prognosis Stated			
6. Reasons for continued care here stated			
7. Plan for Medical Care Complete & Current:			
(a) Written on Admission			
(b) Evidence of being followed			
(c) Treatment, Rehab./Rest'ive Goals Stated			
(d) Spec. health & safety measures stated			
(e) Activities permitted & to be promoted			
(f) Continuing/Alternative/Discharge Care Planned			

(A. Evaluation of Physician Care and Services - cont'd)

FACTOR		Yes	No	REVIEWER COMMENTS
8.	Treatment Orders Complete & Current;			
	(a) Consistent with treatment plans			
	(b) Reviewed by Phys'n at least every 30-days			
	(c) Medication orders revalidated every 30-days			
	(d) Appropriate tests re medication regimen			
	(e) Test results & observations properly recorded			
	(f) Medications compatible with cond. of pt.			
	(g) Stop orders on potentially dangerous drugs			
	(h) Special procedures ordered as appropriate; properly recorded; and results noted			
	(i) Specific dietary regimen prescribed			
9.	Phys'n Progress Notes Complete & Current, & consistent with Observed Condition of Pt.			
10.	Evidence of Treatment Orders Being Followed & Recorded.			

B. EVALUATION OF NURSING CARE AND SERVICES

AS REFLECTED BY SIGNED AND DATED ENTRIES IN THE MEDICAL RECORD OF THIS PATIENT

FACTOR	Yes	No	REVIEWER COMMENTS
1. Written Nursing Care Plan for This Patient is Complete and Current			
2. Evidence that Plan of Care Being Followed			
3. Nursing Care Notations Complete & Current			
4. Nursing Progress Notes Complete & Current			
5. Medications: (a) Administered as ordered by physician (b) Charted as administered (c) Signed when charted			
6. Physician's Treatment Orders: (a) Performed as ordered (b) Charted as performed (c) Signed when performed			
7. Evidence That Rehabilitative/Restorative Nursing Care Attitude & Capability Prevails			
8. Evidence that kindness and consideration characterizes nurse/patient interpersonal and professional relationships			
9. Evidence of Adequate and Suitable Nursing, Personal & Psychosocial Care being Rendered per Observed Condition & Responses of Patient			

C. COMPARATIVE PATIENT CARE ASSESSMENTS

PER REVIEWER CORRELATIONS BETWEEN SUBSTANTIVE CONTENT
OF THIS PATIENT'S MEDICAL RECORD, AND OBSERVED FINDINGS
OF AND INFORMATION ELICITED FROM THE PATIENT

FACTOR	Fac. Rep't	Yes	No	Reviewer Be Alert For!	Reviewer's Findings And Comments
<u>Cleanliness of Patient:</u>	X				
<u>Cleanliness of Clothing/Bed Gown:</u>	X				
<u>Cleanliness of Surroundings:</u>	X				
<u>Presence of Decubiti:</u>	X				
<u>Presence of Dehydration:</u>	X				
<u>Presence of Malnutrition:</u>	X				
<u>Optimum Physical Functioning:</u>	X				
<u>Optimum Mental Functioning:</u>	X				
<u>Optimum Psychosocial Functioning:</u>	X				
<u>Patient Satisfaction & Attitude:</u>	X				
<u>Bed Status:</u>					
<u>Ambulation Status:</u>					

FACTOR	Fac. Rep't		Reviewer Be Alert For!	Reviewer's Findings And Comments
	Yes	No		
Transfer Status:				
Activity Status:				
Mental Status:				
Grooming Status:				
Diet Status:				
Feeding Status:				
Pers. Toilet Status:				
Sensory/Communication Status:				

FACTOR	Fac. Rep't		Reviewer Be Alert For!		Reviewer's Findings And Comments
	Yes	No	Yes	No	
Oral Hygiene Status:					
Nail & Foot Care Status:					
Prosthesis:					
Self-Care Status:					

D. ASSESSMENT OF THIS PATIENT'S DISABLING CONDITIONS

PER REVIEWER CORRELATIONS BETWEEN SUBSTANTIVE CONTENT OF THIS PATIENT'S MEDICAL RECORD, AND OBSERVED FINDINGS OF AND INFORMATION ELICITED FROM THE PATIENT

FACTOR	Fac. Rep't		Reviewer Be Alert For!		Reviewer Findings And Comments
	Yes	No	Yes	No	
Pain:					
Amputation:					
Breathing Difficulty:					

(D. Assessment of This Patient's Disabling Conditions - cont'd)

FACTOR	Fac. Rep't		No	Yes	Reviewer Be Alert For!	Reviewer Findings And Comments
Bed Sores:						
Contractures:						
Comatose:						
Convulsions/Seizures:						
Urinary Incontinence:						
Fecal Incontinence:						
Ileostomy/Colostomy:						
Lesions:						
Tracheostomy:						
Tubes/Catheters:						
Other:						

E. ASSESSMENTS OF TREATMENTS AND NURSING CARE

PER REVIEWER CORRELATIONS BETWEEN SUBSTANTIVE CONTENT
OF THIS PATIENT'S MEDICAL RECORD, AND OBSERVED FINDINGS
OF AND INFORMATION ELICITED FROM THE PATIENT

Code

1 = Less than once daily 3 = More than once daily
2 = Once daily 4 = PRN

THERAPY	Frequency Reported	Reviewer Findings and Comments
Maintenance Drugs	1 2 3 4	
Complex Drugs	1 2 3 4	
Ileostomy/Colostomy Care	1 2 3 4	
Catheterization	1 2 3 4	
Catheter/Tube Change or Irrigation	1 2 3 4	
Enemas	1 2 3 4	
Packs (Cold/Hot)	1 2 3 4	
Sitz Bath or Perineal Care	1 2 3 4	
Soaks	1 2 3 4	
Vital Signs	1 2 3 4	
Lesion Irrigation	1 2 3 4	
Sterile Dressings	1 2 3 4	

THERAPY	Frequency Reported	Reviewer Findings and Comments
Non-Sterile Dressing Change	1 2 3 4	
Fluid Therapy (IV or SQ)	1 2 3 4	
Suctioning	1 2 3 4	
Inhalation Therapy or I.P.P.B.	1 2 3 4	
Tracheostomy Care	1 2 3 4	
Bladder and/or Bowel Training	1 2 3 4	
Succ. Fracture or Prosthetic Care	1 2 3 4	
Intake-Output Measures	1 2 3 4	
Special Skin Care	1 2 3 4	
Range of Motion or Gait Exercises	1 2 3 4	
Feeding Other than By Mouth	1 2 3 4	
Special Bed Care (turning, positioning, etc.)	1 2 3 4	
In-Facility Laboratory Tests	1 2 3 4	
Other Special Care(_ _ _ _ _)	1 2 3 4	

F. ASSESSMENTS OF SPECIAL THERAPIES BEING RECEIVED

PER REVIEWER CORRELATIONS BETWEEN PHYSICIAN'S ORDERS AND INSTRUCTIONS FOUND IN THIS PATIENT'S MEDICAL RECORD AND SPECIAL THERAPIES ACTUALLY GIVEN AND RECORDED, AND OBSERVED BENEFITS AND RESULTS

SPECIAL THERAPY	Observed Benefits And Results	Reviewer's Comments
Physical Therapy		
Occupational Therapy		
Speech/Hearing Therapy		
Podiatry Care		
Psychotherapy		
Dental Care		

G. SOCIAL SERVICE ASSESSMENT OF THIS PATIENT

PER SOCIAL WORKER CORRELATIONS BETWEEN SOCIO-ECONOMIC AND FAMILY DATA, AND OFFICIAL PUBLIC ASSISTANCE AGENCY RECORDS AND AUTHORIZATIONS FOUND IN THIS PATIENT'S MEDICAL RECORD OR MEDICAL ASSISTANCE FILE, AND OBSERVATIONS OF THE PATIENT AND SOCIAL INFORMATION ELICITED FROM HIM

SOCIAL SERVICE CONSIDERATION	Yes	No	Social Work Reviewer's Comments or Recommendation*
Is there a written social plan of care in the patient's medical record; and is it being followed? Has there been any change in it recently?			

SOCIAL SERVICE CONSIDERATION	Yes	No	Social Work Reviewer's Comments or Recommendations
Does the provider facility have social work services available to M.A. patients. If not, how is it, or how can it be made available?			
Are there resources available which could help restore this patient to independent functioning, or to make his life more comfortable and satisfying?			
Are there activities available in the facility in which this patient can take part. If not, why not.			
Is the social information on this patient in his medical record sufficient and current?			
Are there interpersonal stresses between this patient and staff members or other patients in the facility?			
Are there any specific personal or other problems and needs expressed by this patient?			
Family and/or acquaintance psychosocial support and relationships with this patient.			
Social Work Services needed by this patient:			

(ii. Assessment of Progress of This Patient - cont'd)

REVIEWER'S RECOMMENDATIONS:

Composition of Review Team:

M.D.

R.N.

M.S.W.

Others Participating in Review of This Patient:

DATE: / / GENERAL APPRAISAL OF PROVIDER FACILITY AND SERVICES

BASED UPON GENERAL OBSERVATIONS, INQUIRY, AND CONCLUSIONS REACHED
BY THE MEDICAL REVIEW TEAM COLLECTIVELY IN RESPECT TO THE FACILITY'S
RESOURCES, SERVICES, ATTITUDES, AND THE PHYSICAL ENVIRONMENT AND TONE

FACTOR	Satisfactory	Unsatisfactory
1. Adequacy, upkeep, and safety of the physical plant and site		
2. Adherence to good administrative and professional practices		
3. Adequacy of collateral arrangements for special services or care not available in the provider facility		
4. Adequacy of agreements with hospitals and other medical facilities for emergency or routine transfer of patients and relevant clinical and treatment information		
5. Availability of medical director or emergency physician for care of patients when attending physicians are not available or are non-responsive		
6. Equipment and other resources adequate, available, and maintained in good operating condition to meet the health needs of all patients in the facility, and to promote their optimal physical and psychosocial functioning.		
7. Adequacy of a roster of medical and para-medical consultants to provide essential, intermittent services to patients; e.g., dental, psychiatric, orthopedic, podiatry, physiatry, physical therapy, laboratory, x-ray, cardiology, neurology, social services, etc.		
8. Functional utilization review committee		
9. Attitude, response, and cooperation in all aspects of the Medical Review Process		
10. Additional Comments & Summary:		

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Review Team:

M.D.

R.N.

M.S.W

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